The following Q&As address Medicare guidelines on the reporting of breast imaging procedures. Private payer guidelines may vary from Medicare guidelines and from payer to payer; therefore, please be sure to check with your private payers on their specific breast imaging guidelines.

Q: What differentiates a diagnostic from a screening mammography procedure?

Medicare’s definitions of screening and diagnostic mammography, as noted in the Centers for Medicare and Medicaid’s (CMS’) National Coverage Determination database, and the American College of Radiology’s (ACR’s) definitions, as stated in the ACR Practice Guidelines for the Performance of Screening Mammography and Diagnostic Mammography, are provided as a means of differentiating diagnostic from screening mammography procedures. Although Medicare’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. Please go to the CMS and ACR Web sites for detailed comments on these studies.

Medicare Definitions (CMS National Coverage Determination for Mammograms 220.4)

Per the CMS National Coverage Determination, the following definitions for screening and diagnostic mammography are provided:

“A diagnostic mammogram is a radiologic procedure furnished to a man or woman with signs and symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy - proven benign breast disease, and includes a physician's interpretation of the results of the procedure.”

“A screening mammogram is a radiologic 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. A screening mammogram has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast.”

Medicare will not pay for a screening mammogram performed on a woman under the age of 35. Medicare will pay for only one screening mammography procedure performed on a woman over age 34 but under age 40. For an asymptomatic woman over age 39, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

As noted in the Medicare Benefit Policy Manual, Chapter 15 — Covered Medical and Other Health (Section 280.3) “the term ‘screening mammography’ means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer…” Therefore, Medicare does not cover screening mammography for a man.
Medicare will pay for a diagnostic mammogram when one of the following conditions is met:

- A patient has distinct signs and symptoms for which a mammogram is indicated
- A patient has a history of breast cancer
- A patient is asymptomatic but, on the basis of the patient’s history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate

**ACR Definitions (as defined in the ACR Practice Guidelines)**

Screening mammography is a radiological examination to detect unsuspected breast cancer in asymptomatic women. Standard views are obtained, and thus the interpreting physician does not need to be present at the facility to monitor the examination when the patient is imaged.

The examination should ordinarily be limited to craniocaudal (CC) and mediolateral oblique (MLO) views of each breast. On occasion, supplementary views may be required to visualize breast tissue completely or optimally, but such views are not ordinarily part of the routine screening examination except for women with implants. Views may be modified to accommodate patient positioning limitations.

Diagnostic mammography is an radiologic examination performed to evaluate patients who have signs and/or symptoms of breast disease, imaging findings of concern, or prior imaging findings requiring specific follow-up. Diagnostic mammography requires direct supervision. A diagnostic mammogram may include MLO, CC, and/or additional views to evaluate an area of clinical or radiographic concern. Additional mammographic views might include spot compression, spot compression with magnification, tangential views, or other special views. When selecting a view, the proximity of the area of concern to the image receptor should be considered.

The written or electronic request for a diagnostic mammography examination should provide sufficient information to demonstrate the medical necessity for the examination and allow for its proper performance and interpretation.

As noted in Section IV. Patient Selection, of the ACR Practice Guidelines:

Diagnostic mammography may be appropriate for patients:

1. With a specific focus of clinical concern including, but not limited to, mass, induration, axillary lymphadenopathy, some types of nipple discharge, skin changes, or persistent focal areas of pain or tenderness
2. With a possible radiographic abnormality detected on screening mammography
3. Recommended for short-interval follow-up (e.g., less than one year) for probably benign radiographic concerns as defined by the ACR Breast Imaging Reporting and Data System (BI-RADS®)
4. Whose examination requires direct involvement of the radiologist for special views, breast physical examination, or consultation
5. Who have been treated for breast cancer. At the discretion of the facility, asymptomatic women may undergo screening or diagnostic mammography.

When billing for a Medicare patient who has had a mammogram, one must be cautious to follow the Centers for Medicare and Medicaid Services’ definition. One should consult the local Medicare carrier or Medicare Administrative Contractor to determine how to code for some questionable scenarios. Also note that non-Medicare third-party payers should also be contacted as they may handle coverage of screening and diagnostic mammograms differently.

1 Direct supervision is defined as the physician being present and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision may also be accomplished via telemammography as long as the interpreting physician is immediately available.

Q: How are additional views reported when performed during a screening mammography procedure to better visualize breast tissue?

Additional views performed to better visualize breast tissue are considered part of the base procedure performed and not reported separately. Although a screening examination should ordinarily be limited to craniocaudal (CC) and mediolateral oblique (MLO) views of each breast, on occasion, supplemental views may be required to visualize breast tissue completely or optimally, but such views are not ordinarily part of the routine screening examination except for women with implants. When pathology is suspected, a recommendation for additional imaging studies, diagnostic mammography, or biopsy may be warranted.

2 ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography (2008)

Q: What code(s) should be reported to describe a screening mammogram when additional magnification views are required for a suspected abnormality? May I code both a diagnostic mammogram and a screening mammogram and is an order required?

If a screening mammogram is performed and, after review of the images, pathology is suspected and additional views are obtained, Medicare states that it is appropriate to charge for both a screening mammogram and a diagnostic mammogram. If the additional views are done on the same day as the screening mammogram, the diagnostic study should be reported with the GG modifier, as it is used by Medicare for tracking purposes. This modifier designates to Medicare the performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.

When 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.

See Section 20.2 — HCPCS and Diagnosis Codes for Mammography Services for additional information on the reporting of a screening and diagnostic mammogram performed on the same day.

Q: Is it appropriate to combine the interpretation of a screening and a diagnostic study into one report or must two separate reports be issued?

According to the ACR Breast Imaging Reporting and Data System (BIRADS®)* frequently asked questions
(see Multiple Procedures section):

The facility has the option of issuing either separate reports or one combined report. If two reports are issued, each must contain its own overall final assessment (21 CFR 900.12(c)(1)(iv)). In either case, the facility can report the exam(s) on the same piece of paper.

If the facility decides to issue a single combined report, the facility needs to be aware of the following:

1. A combined report must contain a single overall final assessment for the two exams (21 CFR 900.12(c)(1)(iv)).

2. The combined report should make it clear that it is combining the results of the screening and diagnostic studies. This is especially important if questions arise about whether the exams were billed correctly.

3. Issuing a single combined report with a single final assessment may skew the facility’s medical audit results.

4. Though some computerized reporting systems may consider this a single exam (rather than two), FDA [Food & Drug Administration] would still allow facilities to count both exams toward meeting the continuing experience requirement.

*BI-RADS® was developed by the ACR to standardize mammographic reporting, improve communication, reduce confusion regarding mammographic findings, aid research, and facilitate outcomes monitoring.

Q: How do you code for a unilateral screening mammogram in a patient who has had one of her breasts removed? The code descriptor for a screening mammogram specifies that it is a bilateral study.
When a screening mammography study is ordered and performed on a patient who has only one breast, it is appropriate to report 77057 (Screening Mammography, bilateral [2-view] film study of each breast) or G0202 (Screening mammography, producing direct digital image, bilateral, all views). Because the CPT code descriptors for 77057 and G0202 state “bilateral,” it would be appropriate to use a 52 modifier (reduced level of service) to designate a screening procedure of only one breast. However, radiology practices should check with their local carrier and other third-party payers regarding the use of the 52 modifier in this situation, because some payers have stated that a 52 modifier is not necessary for reporting a unilateral screening mammogram.

Q: What is the correct way to code for a mammography examination on a mastectomy patient when one or two additional images are taken of the axillary region on the mastectomy side? Is it correct to report a bilateral mammography code even though there is no breast tissue? Would this be considered a screening or diagnostic study?

Yes, it is correct to code a bilateral mammography examination code even though there is no obvious breast tissue because both the side of the remaining breast and the mastectomy side are being imaged. This is analogous to a mammogram of a man, where there is little breast tissue. Depending on the type of mastectomy performed, there may be residual breast tissue left behind, usually in the axillary tail. If there is enough clinical concern to warrant imaging, there is probably clinical concern that a small amount of breast tissue remains. This should, therefore, be billed as a bilateral diagnostic mammogram (77056 or G0204).

Q: Should a screening mammogram or a diagnostic mammogram be performed on an asymptomatic patient with augmented breasts (e.g., breast implants)?

According to the ACR Practice Guideline for Performance of Screening and Diagnostic Mammography, the facility and/or interpreting physician can determine whether a woman with augmented breasts (breast implants) is imaged as a screening or a diagnostic patient.

However, the Centers for Medicare and Medicaid Services’ (CMS) payment policy for a diagnostic mammogram does not recognize asymptomatic patients with augmented breasts as diagnostic. Medicare will pay only for a screening mammogram for an asymptomatic woman with breast implants.

Because Medicare denies the necessity of a diagnostic mammogram for an asymptomatic patient with augmented breasts, it is recommended that the physician have the patient sign an advance beneficiary notice form so that the radiologist may bill the patient for the procedure. If the patient and referring physician decide that a screening mammogram should be performed, then the patient would receive a screening mammogram.

The ACR guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care…The ultimate judgment regarding the propriety of any specific procedure or course
of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care.

3 ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography, effective October 2008.

Q: What type of mammogram should a patient receive who has a personal history of biopsy-proven benign breast disease?

As noted in the Dec. 8, 1995 Federal Register, the Centers for Medicare and Medicaid Services expanded its definition of diagnostic mammography to include a personal history of biopsy-proven benign breast disease, thereby allowing the attending physician and the patient the opportunity to determine whether a screening mammogram or a diagnostic mammogram is performed.

Q: Is there a guideline that states that patients with a history of mastectomy must revert back to a screening mammography study after a set number of negative diagnostic studies or after a specified number of years postmastectomy?

No, Medicare does not have a specific requirement that a patient with a history of mastectomy must revert back to a screening mammography study after a set number of negative diagnostic studies or after a specified number of years postmastectomy. The Centers for Medicare and Medicaid Services allows the attending physician and the patient the flexibility to choose whether they want to continue with a diagnostic mammogram or revert back to the screening process.

Q: In a freestanding office or independent diagnostic testing facility (IDTF) setting, is a separate order required for a breast ultrasound study recommended by a radiologist to further evaluate a suspicious finding on screening mammography?

Yes, in freestanding office and IDTF settings a separate order is required for the addition of a breast ultrasound study following a screening mammography procedure to further evaluate a suspicious finding. The rationale that allows for the performance of a diagnostic mammogram following a screening mammogram without an order from the referring physician does not apply to additional diagnostic testing such as ultrasound or MRI.

The national office of the Health Care Financing Administration (HCFA) notified the ACR that Medicare proposed and adopted the diagnostic mammography exception to the Ordering of Diagnostic Tests Rule (see Medicare Benefit Policy Manual, Chapter 15, Section 80.6) because Congress made the Food and Drug Administration, rather than HCFA, responsible for the conditions under which mammograms are covered. In addition, the screening mammography benefit contains no requirement for a physician’s order. Thus, a beneficiary could receive the screening mammogram on a walk-in basis, with no treating physician to order the subsequent diagnostic procedure.
Note that the Ordering of Diagnostic Test Rule does not apply in the hospital setting (see Thomas Scully letter to American Hospital Association, Response #1).

**Q: Is it appropriate to separately code for the review of prior mammographic images when those images are not available for comparison at the time of the current mammogram interpretation?**

No, it is not appropriate to separately code for the review of prior mammographic images when they are not available for comparison at the time of interpretation of the current images. The comparison of prior images, which may be an important part of diagnostic mammography, is considered part of the mammography procedure. Radiology practices should work to ensure images are available for comparison at the time of the current mammography reading.

**Q: Is it appropriate to report the mammography computer-aided detection (CAD) codes (77051, 77052) in conjunction with both plain and digital mammography codes?**

Yes, CAD codes 77051 (diagnostic mammography) and 77052 (screening mammography) may be reported with both plain film CPT codes 77055, 77056, 77057, and digital Healthcare Common Procedural Coding System (HCPCS) codes G0202, G0204, G0206. Medicare and many private payers reimburse for the use of CAD.

The Medicare Claims Processing Manual, Chapter 18, Section 20.2.1, specifies that effective for claims with dates of service January 1, 2007 and later the CAD code 77051 may be used in conjunction with a diagnostic mammography code (77055, 77056, G0204 or G0206), and CAD code 77052 may be used in conjunction with a screening mammography code (77057 or G0202).

**Q: How should the use of computer-aided detection (CAD) software be reported in conjunction with breast sonography services?**

CAD performed in conjunction with breast sonography is reported with the unlisted CPT code 76999 (Unlisted ultrasound procedure (e.g., diagnostic, interventional)) to describe the CAD analysis and CPT code 76645 (Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation) to describe the breast ultrasound study. Although CAD codes have been established to be used in conjunction with diagnostic and screening mammography (77051, 77052) and breast magnetic resonance imaging (0159T), no code is available to describe CAD performed in conjunction with breast ultrasound; therefore, the unlisted procedure code should be reported.
Q: The descriptor for the magnetic resonance imaging (MRI) computer-aided detection (CAD) code, 0159T, specifies including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis. Is it appropriate to report this code when pharmacokinetic analysis is not performed?

Yes, it is appropriate to report the Category III code 0159T to describe CAD performed in conjunction with a breast MRI study even though pharmacokinetic analysis is not performed. Code 0159T should be used to describe any type of CAD (Confirma, In-Vivo, CAD Sciences, etc.) performed in conjunction with an MRI of the breast. The phrase “including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis” in the descriptor clarifies that this code includes this type of analysis if performed, and it should not be coded separately. Code 0159T is an add-on code to a breast MRI procedure and, therefore, must be reported in addition to one of the breast MRI without and/or with contrast codes (77058 unilateral, 77059 bilateral). This coding recommendation is clarified in the AMA/ACR Clinical Examples in Radiology (Volume 3, Issue 2, Spring 2007).

Also note, that because the CAD software automatically performs three-dimensional (3D) imaging, the CAD procedure code was valued to include 3D imaging, and codes 76376 and 76377 should not be reported in addition to 0159T.

At this time, the ACR Commission on Economics is working with the Commission on Breast Imaging and the Breast Imaging Economic Committee to determine the best time to migrate 0159T to a Category I CPT code status based on the required literature support and extent of utilization of this technology.

Q: When digital subtraction is used in conjunction with a breast magnetic resonance imaging (MRI) with contrast study, is it appropriate to report code 76350 (Subtraction in conjunction with contrast studies)?

No, the subtraction code 76350 (Subtraction in conjunction with contrast studies) was developed prior to digitization when the creation of plain film subtraction images was done in the darkroom. Code 76350 should not be reported in addition to the code for a breast MRI with contrast study or any other MRI study.

Digital subtraction is a scanner-performed function that generates another set of images. This is similar to another pulse sequence in MRI or another set of windows in computed tomography. Therefore, the digital subtraction would be inherent in the breast MRI procedure. It is not a postprocessing function on a separate workstation.

Q: Is it appropriate to report the 3-D rendering code 76376 when the referring physician did not include 3-D in the order?

In the past, the ACR maintained that an order for 2D and 3D reconstruction imaging was not necessary because this was covered under the Ordering of Diagnostic Tests Rule test design exception (Chapter 15, Medicare Benefit Policy Manual, Section 80.6.4). However, based on the exponential rise in the use of 3D rendering codes 76376 (not
requiring image postprocessing on an independent workstation) and 76377 (requiring image postprocessing on an independent workstation) and in the number of practice investigations evolving out of overutilization (routine use), the ACR strongly encourages radiology practices to obtain an order from the referring physician in the nonhospital setting. In the hospital setting, radiologists may generate their own order, but they are strongly encouraged to justify medical necessity for the use of 3D rendering in a separate dictation.

Q: Is an order required for the use of computer-aided detection (CAD) with breast imaging procedures, such as mammography, magnetic resonance imaging (MRI) and ultrasound? Must the use of CAD be dictated in the report?

No, an order is not required for the use of CAD performed in conjunction with breast imaging procedures, such as mammography, MRI, and ultrasound. As noted in the Winter 2007 issue of the AMA/ACR Clinical Examples in Radiology, an order is not required for the performance of CAD because CAD is covered under the Ordering of Diagnostic Tests design exemption (Section 80.6.4).

The Centers for Medicare and Medicaid Services informed the ACR that the Ordering of Diagnostic Tests Rule allows for performance of CAD in conjunction with mammography without a written order from the referring (treating) physician. Because there is no medical necessity prerequisite for the use of CAD with mammography procedures, and if all aspects of CAD are performed in conjunction with mammography, the radiologist may determine whether or not CAD should be performed. The use of CAD is covered under the Radiologist Exception as noted in Medicare Transmittal #1725:

**15021 (E)(1) Test Design — Unless specified in the order, the radiologist may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or nonuse of contrast media).**

*When CAD is used in addition to a breast imaging procedure, it should be documented in the report.*

Q: Is it appropriate to report the code for a placement of a metal clip (19295) when performed after a breast aspiration biopsy (10022) procedure? The CPT code book lists a cross-reference that states 19295 should be used in conjunction with 19102 and 19103. It does not say to use with 10022.

Yes, it is appropriate to report the clip placement CPT code +19295 (*Image guided placement, metallic clip, percutaneous, during breast biopsy*) in addition to the breast aspiration biopsy code 10022 (*Fine needle aspiration with imaging guidance*) if the fine needle aspiration procedure is done to obtain samples for a biopsy. The CPT code book cross-reference under code 19295 (*Use 19295 in conjunction with 19102, 19103*) was not intended to exclude the use of other breast biopsy codes.
Q: Is it appropriate to code for a mammogram following a vacuum-assisted, image-guided biopsy and tissue marker placement?

The coding for a mammogram following a vacuum-assisted, image-guided breast biopsy and tissue marker placement would depend on the imaging modality used, as well as the number of physicians involved. A vacuum-assisted, image-guided breast biopsy is appropriately reported with code 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) for the biopsy, 77031 for the stereotactic localization (radiologic supervision and interpretation, which includes all imaging), and 19295 for the placement of the tissue marker.

If all of the imaging takes place on a stereotactic machine and is performed by the same physician, the postprocedure mammogram is included in code 77031. Code 77031 includes all of the imaging and work involved by a physician to perform this procedure. Therefore, it is not appropriate to code for the follow-up mammogram.

There are instances, however, when it would be appropriate to code separately for a mammogram post breast biopsy. For example, it is appropriate to bill for a verification mammogram if the biopsy is done under ultrasound guidance. The rationale for this is that the mammogram is a separate procedure using a different imaging modality and it is not essential to the successful completion of the ultrasound-guided procedure.

Another instance when it would be appropriate to code separately for a follow-up mammogram is when a surgeon does the stereotactic procedure and clip placement, and then refers the patient to radiology for a follow-up mammogram or ultrasound. In this instance, it is appropriate for the radiologist to code for the mammogram or ultrasound study performed. This is one of many examples where coding is dependent on whether there is one or multiple physicians involved in the steps of the procedure.

Q: What CPT code(s) should be used to report a percutaneous breast biopsy?

The choice of the appropriate breast biopsy CPT code is based on the technique used, that is, whether the study was performed percutaneously (19100) or open (19101), and whether or not it was performed with image-guidance (19102, 19103) or without image guidance (19100).

CPT code 19100 describes a needle core biopsy when imaging guidance is not required, for example, a biopsy of a palpable breast lesion. Code 19102 describes an image-guided needle core biopsy, and 19103 describes an image-guided biopsy using an automated vacuum-assisted or rotating biopsy device. When imaging guidance is used in conjunction with a breast biopsy procedure, the guidance should be reported separately using one of the modality-specific guidance codes. For example, guidance should be reported by 76942 for ultrasound, 77012 for computed tomography, 77021 for magnetic resonance imaging, 77031 for stereotactic localization, or 77032 for mammography.
Please note that when performing breast biopsies, if multiple breast biopsies are performed, the biopsy procedure code and radiological supervision and interpretation (imaging) codes are submitted per lesion and NOT per sample.

**Q: If a physical exam is performed in conjunction with a diagnostic mammogram or breast ultrasound and the results are discussed with the patient, is it appropriate to bill for an office visit (e.g., 99212) if performed in a private office setting?**

It is only appropriate to bill for a consultation or other evaluation and management (E&M) service when the service is provided and documented according to established E&M guidelines. For breast interventional procedures, a brief review of history and physical exam and obtaining informed consent is not a separately reportable E&M service. The Relative (Value Unit) Update Committee (RUC) database clearly indicates that such discussion of findings with the patient is part of the valued work (and thus reporting this separately with an E&M code is unbundling).

A copy of the [1995](#) and [1997](#) E&M published guidelines are available on the Centers for Medicare and Medicaid Services web site. It is up to the provider to choose which published guidelines to follow. However, it is recommended that for auditing purposes a radiology practice use one set of guidelines, that is, either 1995 or 1997.

**Q: Is a consent form signed by the patient required for a breast cyst aspiration?**

Yes, a signed informed consent form must be obtained prior to the performance of a breast cyst aspiration or breast core biopsy. Obtaining a consent form from the patient for these breast procedures is no different from obtaining a consent form for any other invasive or interventional procedure.

**Q: Is it appropriate to report a diagnostic magnetic resonance imaging (MRI) study code and an MRI guidance code when MRI guidance is performed for breast biopsy?**

Yes, if a diagnostic MRI breast study is performed on the same day as the MRI-guided breast biopsy, it is appropriate to report the diagnostic MRI code and the MRI guidance code, as well as the appropriate surgical code for the breast biopsy. However, if a diagnostic MRI study has been performed prior to the breast biopsy and MRI sequences are performed for localization purposes only, these sequences are part of the guidance and should not be reported separately.

*Because MRI can detect lesions not seen by other imaging methods or by physical examination, the use of MR guidance in breast biopsies is a valuable adjunct to diagnostic breast MR.*

*Patients should undergo standard mammography prior to breast MRI, and the mammography study and report should be available for review...The written or electronic request for MRI of the breast should provide sufficient information to demonstrate the medical necessity of the examination and allow for the proper performance and*
See the Fall 2005 issue of Clinical Examples in Radiology for additional information on the performance of breast MRI.


Q: Is it appropriate to report the ultrasound guidance CPT code 76942 in conjunction with the aspiration code 10022 when a fine needle aspiration of the breast is performed under ultrasound guidance?

Yes, it is appropriate to report the ultrasound guidance code 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) in conjunction with the aspiration code 10022 (Fine needle aspiration; with imaging guidance) when a fine needle aspiration of the breast is performed using ultrasound guidance. Fine needle aspiration biopsies are differentiated by those performed without imaging guidance (10021) and those performed with imaging guidance (10022). The imaging (fluoroscopy, computed tomography, magnetic resonance imaging, or ultrasound) guidance used should be reported in addition to 10022 using the appropriate guidance code (77002, 77012, 77021, or 76942).

Q: How are multiple ultrasound-guided breast cyst aspirations of the same breast reported?

The number of breast cyst aspirations reported is based on the number of breast cyst aspirations performed. For example, if three breast cysts are aspirated under ultrasound guidance, it is appropriate to report 19000 once, for the first cyst aspirated, 19001 twice, for the second and third cysts aspirated, and 76942 three times, for the ultrasound guidance. The ultrasound image guidance is reported per cyst aspirated.


Q: Can you report a breast biopsy code multiple times when multiple samples are taken from the same lesion?

No, if multiple samples are taken from the same lesion, the biopsy code should be reported only once. However, when separate lesions are sampled during the same session, it is appropriate to report the biopsy code multiple times based on the number of separate lesions sampled.
Q: Some third-party payers do not recognize the full-field-digital mammography (FFDM) Healthcare Common Procedure Coding System Level II codes (G0202, G0204, and G0206). How should FFDM be reported to these payers?

If nonMedicare payers deny payment for the full-field digital mammography (FFDM) because their systems cannot recognize the "G" codes established (G0202, G0204, G0206) by Medicare, it is appropriate to use the plain film mammography CPT codes 77055, 77056 and 77057 for diagnostic and screening mammography in their place to describe the FFDM procedures. Codes 77055, 77056 and 77057 should be reported with a 22 modifier to describe the additional work. It is recommended that providers check with their third party payers for any specific payer requirements.

Q: What supervision level is required for a diagnostic mammogram?

There is nothing in the regulations that requires supervision by a radiologist for mammography procedures.

The October 31, 1997, the Healthcare Financing Administration [now known as the Centers for Medicare and Medicaid Services (CMS)] final rule clarifying the appropriate level of physician supervision for diagnostic tests payable under the Medicare Physician Fee Schedule does not apply to mammography procedures. Mammography is covered under the Food and Drug Administration’s Mammography Quality Standards Act (MQSA) guidelines, which also do not address the issue of supervision.

However, the ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography recommends direct supervision of diagnostic procedures. Direct supervision is defined as the physician being present and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision may also be accomplished via telemammography as long as the interpreting physician is immediately available.

Q: What ICD-9 codes should be used to report a screening mammography study? Must this code be listed as the primary diagnosis code or would a positive finding be reported as the primary code?

Code V76.11 (Special screening for malignant neoplasm, screening mammogram for high-risk patients) or code V76.12 (Special screening for malignant neoplasm, other screening mammography) should be reported as the primary diagnosis code when screening mammography is performed even when the outcome of the study renders a positive finding.

As noted in Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services of the ICD-9-CM Official Guidelines for Coding and Reporting
• Tests performed without clinical signs or symptoms should be reported with the reason for the test (e.g., screen) as the primary diagnosis. The results of the test may be reported as additional diagnoses.

Also refer to *Chapter 18, Medicare Claims Processing Manual, Section 20.2 - HCPCS and Diagnosis Codes for Mammography Services* for additional information on the reporting of ICD-9 codes for mammography procedures.

**Q: What is a breast tomosynthesis study and how is it coded?**

Breast tomosynthesis is an exam in which a volume of image data is acquired of the breast allowing for subsequent reformatting that reduces the effect of overlying dense tissue in obscuring abnormalities. It is akin to the volumetric acquisition of data in computed tomography.

Because tomosynthesis does not yet have the approval of the Food and Drug Administration (FDA), it should not be reported. At this time, tomosynthesis is available only for research purposes. The ACR will request a code to describe breast tomosynthesis when the FDA has approved the device and the study is implemented in at least a handful of centers across the United States. A new code will be required because the current digital mammography Healthcare Common Procedure Coding System codes G0202, G0204, and G0206 describe a procedure that is acquired by direct digital imaging. Tomosynthesis, although digital, is not acquired through direct digital imaging.

**Q: How is a breast ultrasound coded when performed for skin marking prior to surgical excision of intraductal papillary lesions reported?**

The breast ultrasound code 76645 (*Ultrasound, breast(s) (unilateral or bilateral) real time with image documentation*) should be reported to describe the ultrasound performed for skin marking prior to surgical excision of an intraductal papillary lesion(s) when a diagnostic report is given. This is similar to an ultrasound study performed for the marking of a pleural effusion or ascites for aspiration by a nonradiologist. The ultrasound guidance code 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration injection, localization device), imaging supervision and interpretation*) would not apply, as it is intended for the placement of a needle. Please see the Fall 2008 AMA/ACR Clinical Examples in Radiology for additional comments on breast ultrasound.

**Q: Breast imagers are asked for second opinions quite often, which many times can reduce the amount of additional imaging and, more important, eliminate unnecessary biopsies. How would you report a second opinion or a re-read?**

When a physician’s opinion or advice regarding a specific film is requested by another physician, and on examination of the film the consulting physician provides his or her opinion or advice to the requesting physician in a written report, the specific procedure code with a 26 modifier (professional component only) should be used.
Some Medicare carriers require that a 77 modifier also be used to indicate that a basic procedure or service performed by another physician had to be repeated. Please check with your local Medicare carrier for their guidelines. Other carriers and third-party payers may have different guidelines and may recommend the use of CPT code 76140 (Consultation on X-ray exam made elsewhere, written report).

As noted in the American Medical Association’s Principles of CPT Coding, if a patient comes to an office for a new or established patient visit and brings the physician his or her medical records, including X-rays, the review or reread of the X-rays would be considered part of the face-to-face evaluation and management service provided to the patient and would not be reported separately.

For more information on second opinions, please reference Dr. Richard Duszak’s article “Another Unpaid Second Opinion,” JACR, Volume 2, Issue 9, Pages 793-794 (September 2005).

**Q: Does Medicare pay for a breast ultrasound when performed as a screening study?**

No, Medicare does not pay for a breast ultrasound when performed as a screening study, as Medicare pays for screening studies only when they are Congressionally mandated. Medicare will pay for a diagnostic breast ultrasound if medically indicated.

If breast ultrasound is performed as a screening study, a Medicare patient would be responsible for payment. Noncovered services (ie, services excluded by law or under a nonbenefit category) do not require that a waiver (Advance Beneficiary Notice) be signed, and the patient is responsible for payment. Click here for more information on Medicare’s Advance Beneficiary Notices.

**Q: How is the placement of a metallic localization clip reported when not performed in conjunction with a breast biopsy procedure?**

The placement of a metallic localization clip should be reported with the unlisted breast procedure code 19499. CPT code +19295 (Imaged guided placement, metallic localization clip, percutaneous, during breast biopsy (list separate in addition to code for primary procedure) cannot be reported because it is an add-on code and it is specific to the placement of a clip during a biopsy procedure. The relative value unit (RVU) practice expense component of 19295 covers the cost of the clip. There are no physician work RVUs associated with this code. Code 19295 was added as a way for the facility or the office to recover the cost of the clip.

**Q: What national provider identifier (NPI) number should be reported when a self-referred mammography patient is seen?**

The Centers for Medicare & Medicaid Services has instructed providers to use the institution’s NPI number for self-referred mammograms for all claims submitted on or
Institutional providers submitting claims for self-referred mammography services will duplicate the institution’s own NPI in the attending physician NPI field on their claims; and

Suppliers submitting claims for self-referred mammography services will duplicate the supplier’s own NPI in the attending/referring physician NPI field on their claims.

Q: We are currently performing bilateral breast scintigraphy procedures using an FDA-approved optimized small field-of-view detector in planar acquisitions. How should this be reported?

Both the ACR and the Society of Nuclear Medicine recommend that CPT code 78800 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area) be reported for a breast scintigraphy study of either one or both breasts. Although it is recognized that there is more work in imaging both breasts, the original intent of the multiple areas CPT code (78801) refers to multiple sites in the body versus both sides of the same part of the body. Just as imaging of the chest for other nuclear medicine procedures is considered one single limited area, both breasts are considered a single limited area as well.