Coding for Mammography Services

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by Stacie L. Buck, RHIA, CCS-P, LHRM, RCC

You're diligently auditing outpatient diagnostic services when you find an order in the medical record for a screening mammogram. However, a diagnostic mammogram was performed, not a screening mammogram.

The business office and the patient request that you change the diagnostic code to a screening exam code because the patient has received a co-insurance bill for the diagnostic exam. The patient has full coverage for a screening mammogram, but because the screening mammogram was reported the insurance company did not pay the entire cost for the diagnostic exam. If you have experienced this frustration, you are not alone.

One would think that coding mammography services would be easy as there are only a few mammography codes (see "Mammography Codes" [below]). So why does this scenario occur on a daily basis in facilities across the country? This article answers this question and addresses other common issues on coding mammography services.

Mammography Codes

Code	Descriptor
77055	Mammography; unilateral
77056	Mammography; bilateral
77057	Screening mammography, bilateral (two-view films study of each breast)
+77051	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)
+77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)
G0202	Screening mammography, producing direct digital image, bilateral, all views
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views

Q: What differentiates a screening mammogram from a diagnostic mammogram?

Screening mammography is typically performed on asymptomatic patients, those that do not demonstrate any signs or symptoms of breast cancer or other abnormality. During a screening mammogram craniocaudal and mediolateral oblique views are obtained of each breast. On occasion, additional views may be obtained; however, the number of views alone should not dictate whether a screening mammogram or a diagnostic mammogram is coded.

Diagnostic mammography is usually performed when a patient shows signs or symptoms of a breast abnormality. Medicare covers a diagnostic mammogram when the patient has clinical signs or symptoms that indicate possible breast cancer, an abnormal screening mammogram, a personal history of breast cancer, or a personal history of biopsy proven benign breast disease. Medicare also recognizes that there may be instances when a woman is asymptomatic, but based on her history and other factors a diagnostic exam may be appropriate. During the diagnostic mammogram the craniocaudal and mediolateral oblique views are obtained, as well as additional images, as needed. Additional images include mediolateral or lateromedial views.

Q: Why is there so much confusion as to which exam is most appropriate?

Differing payer guidelines may be one source of confusion coupled with clinical practice guidelines established by the American College of Radiology (ACR). ACR has issued guidelines regarding when it is clinically appropriate to perform a diagnostic mammogram rather than a screening exam.

The table below summarizes the differences between guidelines established by ACR and the Centers for Medicare and Medicaid Services (CMS).

Differing Guidelines

	ACR Recommendation	CMS Guideline
Implants	Asymptomatic=diagnostic Symptomatic = diagnostic	Asymptomatic=screening Symptomatic =diagnostic
History of benign-biopsy proven benign disease	Diagnostic	Diagnostic or screening as determined by the referring physician
History of mastectomy	Diagnostic (lifelong)	May revert to screening as determined by the referring physician

Source: American College of Radiology. "Mammography Coding Q&A." ACR Coding Source, May/June 2006.

To add to the confusion, not all Medicare carriers adhere to the CMS policy, nor do other third-party payers. It is important to review the local coverage determinations for your Medicare carrier and any written policies that have been adopted by other third-party payers in determining which exam is most appropriate.

Q: What is the difference between digital mammography and computer-aided detection? Can the codes for both digital mammography and computer-aided detection be reported together?

According to ACR, "Digital mammography, also called full-field digital mammography (FFDM), is a mammography system in which the x-ray film is replaced by solid-state detectors that convert x-rays into electrical signals. These detectors are similar to those found in digital cameras. The electrical signals are used to produce images of the breast that can be seen on a computer screen or printed on special film similar to conventional mammograms."[1]

Computer-aided detection (CAD) systems differ. They use a "digitized mammographic image that can be obtained from either a conventional film mammogram or a digitally acquired mammogram."[2]

It is a common misconception that the codes for digital mammography and computer-aided detection cannot be reported together. If CAD (77051, 77052) is performed in conjunction with FFDM (G0202, G0204, G0206), both exams should be coded. Recently some payers have incorrectly denied these services when reported together.

Q: What qualifies a patient as high risk for breast cancer?

According to CMS, a woman is at a higher risk for breast cancer if she:

- Has a personal history of breast cancer (V10.3)
- Has a family history (mother, sister, daughter) of breast cancer (V16.3)
- Had her first baby after age 30 (V15.89)
- Has never had a baby (V15.89)

If a woman has any of these risk factors, code V76.11, Screening mammogram for high-risk patient, should be assigned as the primary diagnosis, and the appropriate code for the risk factor(s) should be assigned as secondary diagnosis codes.

Q: Can an evaluation and management service be billed in conjunction with a diagnostic mammogram?

The same rules apply to billing evaluation and management services with diagnostic mammograms as other diagnostic services. To bill for a separate evaluation and management service, all documentation guidelines for the appropriate level of service must be met and the radiologist must perform additional work above and beyond the normal pre- and post-service work associated with a diagnostic mammogram.

A brief review of a patient's history, physical exam, and obtaining informed consent are all considered "bundled" into the reimbursement for a diagnostic mammogram. Also included are the discussion of findings and recommendations made by the radiologist.[3,4]

Q: Is it appropriate to report a post-procedure mammogram following a procedure such as a biopsy?

ACR Coding Source states that reporting a mammogram following a vacuum-assisted, image-guided breast biopsy and tissue marker placement depends on the modality used and the number of physicians involved.[5]

The breast biopsy is reported with code 19103 for the percutaneous vacuum-assisted breast biopsy using imaging guidance, code 77031 is reported for the stereotactic localization, and code 19295 for the placement of the tissue marker. The post-procedure mammogram is included in code 77031 when all of the imaging takes place on a stereotactic machine and is performed by the same physician. Therefore, it is not appropriate to code for the follow-up mammogram.

It would be appropriate to report a mammogram separately following a vacuum-assisted breast biopsy procedure performed with ultrasound guidance. The rationale 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 guidance procedure.

It is also appropriate for a radiologist to report a post-procedure mammogram or ultrasound study when a surgeon performs a stereotactic procedure and clip placement and then refers the patient to radiology for a follow-up mammogram or ultrasound. This scenario also illustrates the importance of quality clinical documentation in order to determine whether there are one or multiple physicians involved in the entire procedure.

Mammography Case Studies

A Medicare patient with a history of breast cancer who has had a unilateral mastectomy presents several years later for a screening mammogram. Which codes should be reported?

The screening exam should be performed and billed as 77057-52, V76.11, V10.3.

If a screening and diagnostic mammogram are both performed on the same day, how should these services be reported?

In the event a screening mammogram reveals an abnormality in which the exam must be converted to a diagnostic exam, Medicare will provide reimbursement for both a screening mammogram and diagnostic mammogram performed on the same date of service. The –GG modifier must be appended to the code for the diagnostic mammogram. It is important to note that other third-party payers may only provide reimbursement for the diagnostic exam.

Notes

1. Radiology Info. "Mammography." Available online at www.radiologyinfo.org/en/info.cfm?pg=mammo&bhcp=1.
2. Ibid.
3. American College of Radiology. "Mammography Coding Q&A." *ACR Coding Source*, May/June 2006.
4. American Medical Association and ACR. "Radiology FAQ." *Clinical Examples in Radiology* 2, no. 2 (Spring 2006): 7.
5. American College of Radiology. "Coding Q&A." *ACR Coding Source,* Jan./Feb. 2004.

Suggested Medicare Resource

Centers for Medicare and Medicaid Services. “Guide to Medicare Preventive Services.” June 2006. Available online at www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.

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Article citation:
Buck, Stacie L. "Coding for Mammography Services" *Journal of AHIMA* 78, no.7 (July 2007): 86-88.