REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
10/31/2013	10/04/2018	05/01/2018
Policy Name		**Policy Number**
Breast Imaging		PY-0028
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Breast Imaging

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

CareSource will reimburse participating providers for medically necessary and preventive screening tests for breast cancer as required by federal statute through criteria based on recommendations from the U.S. Preventive Services Task Force (USPSTF) and American College of Radiology (ACR).

Mammography is the utilization of a low-dose x-ray imaging system for the examination of the breasts and is currently considered to be the best available method for early detection of breast cancer, particularly in the case of small or non-palpable lesions.

This imaging is often employed for screening purposes in an effort to reduce morbidity and mortality of unsuspected breast cancer through earlier detection and treatment in asymptomatic patients. A Screening Mammogram typically includes two standard views of each breast (cranio-caudal and medial lateral oblique) and does not require the presence of, or monitoring by the interpreting radiologist. When abnormalities are observed a diagnostic test is required to confirm the presence of malignancy.

C. DEFINITIONS

- **Technical Component (TC)** – services rendered outside the scope of the physician's interpretation of the results of an examination.
- **Professional Component (PC)** – physician's interpretation of the results of an examination.
- **Global Component** – encompasses both the technical and professional components.
  - See "Breast Imaging Medical Policy-MM0051" for further definitions

D. POLICY

I. CareSource does not require prior authorization for screening and diagnostic mammograms.

II. All other breast imaging, other than x-ray mammograms, require a prior authorization.

III. CareSource reimburses for screening and diagnostic mammograms according to CareSource Medical policy MM-0051. Members must meet the criteria found in medical policy MM-0051.

IV. CareSource considers diagnostic mammography medically necessary for men and women with signs and symptoms of breast disease or a history of breast malignancy.

V. When billing for mammography services, provider should use the appropriate CPT/HCPCS

codes and modifiers, if applicable.

Note: Global billing is not permitted for services furnished in an outpatient facility. Critical Access Hospitals (CAHs) may not use global HCPCS codes as the TC and PC components are paid under different methodologies.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the appropriate Ohio Medicaid fee schedule-http://medicaid.ohio.gov/Portals/0/Providers/FeeScheduleRates/App-DD.pdf.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced sources for the most current coding information.**

CPT Codes Mammography	
Code	**Description**
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
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
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)

CPT Codes Requiring Prior Authorization	
Code	**Description**
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post-processing on an independent workstation
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77053	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation
77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
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)
C8903	Magnetic resonance imaging with contrast, breast; unilateral

C8904	Magnetic resonance imaging without contrast, breast; unilateral
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral
C8906	Magnetic resonance imaging with contrast, breast; bilateral
C8907	Magnetic resonance imaging without contrast, breast; bilateral
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral

F. RELATED POLICIES/ RULES

Breast Imaging Medical Policy, MM-0051

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	10/31/2013	New Policy.
Date Revised	10/31/2013 06/06/2016 10/04/2017	
Date Effective	05/01/2018	

H. REFERENCES

1. American Cancer Society. (2017, September). Retrieved September 25, 2017, from http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs
2. U.S. Preventive Services Task Force; Breast Cancer: Screening. (2016, January). Retrieved September 25, 2017, from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1?ds=1&s=mammography
3. Laboratory and radiology services. (2014, July). Retrieved September 25, 2017, from http://codes.ohio.gov/oac/5160-4-25

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.