MAMMOGRAMS (NCD 220.4)

Guideline Number: MPG202.05

Approval Date: May 8, 2019

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Related Medicare Advantage Coverage Summaries

- Preventive Health Services and Procedures
- Radiologic Diagnostic Procedures

POLICY SUMMARY

Overview

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

A diagnostic mammography 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.

Guidelines

Payment may not be made for a screening mammography performed on a woman under age 35. Payment may be made for only one screening mammography 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.

A radiological mammogram is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- 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.

Use of mammograms in routine screening of: (1) asymptomatic women aged 50 and over, and (2) asymptomatic women aged 40 or over whose mothers or sisters has had the disease, is considered medically appropriate, but would not be covered for Medicare purposes.

A diagnostic mammography is a covered service if it is ordered by a doctor of medicine or osteopathy as defined in §1861(r) (1) of the Act.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.
### CPT Code | Description
--- | ---
#### Screening Codes
- **77063** | Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
- **77067** | Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

#### Diagnostic Codes
- **77065** | Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- **77066** | Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral

### HCPCS Code | Description
--- | ---
#### Screening Code
- **G0202** | Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed *(Deleted 12/31/2017)*

#### Diagnostic Codes
- **G0204** | Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral *(Deleted 12/31/2017)*
- **G0206** | Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral *(Deleted 12/31/2017)*
- **G0279** | Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065-77067)

### Modifier | Description
--- | ---
- **26** | Professional component
- **GG** | Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- **GH** | Diagnostic mammogram converted from screening mammogram on same day
- **LT** | Left side (used to identify procedures performed on the left side of the body)
- **RT** | Right side (used to identify procedures perform on the right side of the body)
- **TC** | Technical component

### QUESTIONS AND ANSWERS
1. **Q:** How should breast tomosynthesis (three-dimensional (3D) mammography) be reported?
   **A:** Breast tomosynthesis should be reported using the applicable mammography code (77065-77067) along with the applicable add-on tomosynthesis code (77063 or G0279).

### PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:
- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.
REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 220.4 Mammograms

CMS Local Coverage Determinations (LCDs)

<table>
<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<tr>
<td>L36342 (Screening and Diagnostic Mammography) First Coast</td>
<td>FL, PR, VI</td>
<td>FL, PR, VI</td>
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<tr>
<td>L33950 (Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography) CGS</td>
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<td>KY, OH</td>
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CMS Articles

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<tr>
<th>Article</th>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<tr>
<td>A54846 (Screening and Diagnostic Mammography-Coding Guidelines) First Coast</td>
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<td>A55873 (Screening and Diagnostic Mammography Revision to the Part A and Part B LCD) First Coast</td>
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<td>A54906 (Screening and Diagnostic Mammography Revision to the LCD) First Coast</td>
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<td>A56448 (Billing and Coding for Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography) CGS</td>
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CMS Benefit Policy Manual
Chapter 1; § 50 Other Diagnostic or Therapeutic Items or Services
Chapter 15; § 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests

CMS Claims Processing Manual
Chapter 18; § 20 Mammography Services (Screening and Diagnostic)

CMS Transmittals
Transmittal 705, Change Request 3562, Dated 10/07/2005 (Modification to Reporting of Diagnosis Codes for Screening Mammography Claims)
Transmittal 1792, Change Request 9861, Dated 02/03/2017, (ICD-10 Coding Revisions to National Coverage Determination (NCDs))
Transmittal 1798, Change Request 9982, Dated 02/17/2017, (ICD-10 Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 1975, Change Request 10318, Dated 11/09/2017 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 2202, Change Request 11005, Dated 11/09/2018 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs))
Transmittal 3146, Change Request 8874, Dated 12/11/2014 (Preventive and Screening Services - Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy)
Transmittal 3160, Change Request 8874, Dated 01/07/2015 (Preventive and Screening Services - Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy)

MLN Matters
Article MM7818, International Classification of Diseases, 10th Edition (ICD)-10 Conversion from (ICD-9) and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations (NCDs) (CR 1 of 3) (ICD-10)
Article MM8109 Revised, International Classification of Diseases 10th Edition (ICD-10) Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs)
Article MM8197, International Classification of Diseases (ICD)-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations (NCDs)
GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<th>Date</th>
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<tr>
<td>05/08/2019</td>
<td>• Annual review</td>
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<td></td>
<td>• CPT coding updated; removed 77052, 77057, 77051, 77055, 77056</td>
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TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.