Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Update Your Understanding of Mammogram Code Reimbursements

Question: Our provider ordered a diagnostic, bilateral mammogram with tomosynthesis for a male patient suffering from mastodynia. However, when we billed 77066 with G0279, Medicare denied our claim using reason code C07 (Patient gender is inconsistent with procedure code). The Medicare rep told us that we needed a modifier that would indicate the patient was male, but we can find no such modifier. What should we do under the circumstances?

Michigan Subscriber

Answer: The problem with billing 77066 (Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral) with G0279 (Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206) is not that the codes need a modifier.

Per the Medicare National Coverage Determination Manual Chapter 1 Part 4 Section 220.4, "A diagnostic mammography is a radiologic procedure furnished to a man or woman with signs and symptoms of breast disease" (Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf). So, if your provider has documented N64.4 (Mastodynia) for your patient, you can provide a diagnostic mammogram service regardless of gender.

The problem, however, seems to lie in the way the Centers for Medicare and Medicaid Services (CMS) has been handling payments for 77066. CPT® introduced 77066 and two other mammography codes effective Jan. 1, 2017. However, the Medicare Physician Fee Schedule (PFS) assigned a status of "I" to these codes, "indicating that these codes are not payable under the PFS until Jan. 1, 2018" (Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3961CP.pdf).

In other words, Medicare was not paying for any 77066 services for the entire 2017 calendar year. Instead, CMS instructed providers to report code G0204 (Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral) rather than 77066 on claims with dates of service Jan. 1, 2017 through Dec. 31, 2017.

On February 2, 2018, CMS released Transmittal 3961, which contained "instructions to modify system edits to pay claims containing code 77065, 77066, or 77067" (Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3961CP.pdf). So, CMS will be paying for 77066 moving forward, but you should check with your Medicare Administrative Contractor (MAC) to see if CMS will process claims with dates of service prior to Jan. 1, 2018, with that code or whether you need to re-submit with code G0204 in lieu of 77066.

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