This drafted policy is open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

HHSC is performing a targeted review of the Screening and Diagnostic Studies of the Breast benefit for Medicaid clients to add digital breast tomosynthesis (DBT) as a new benefit.

The following is a summary of changes in scope for this policy review:

- Added: Policy language for screening and diagnostic digital breast tomosynthesis (DBT).
- Changed: Policy language for breast ultrasound.

Some policy language that is out of scope for this review is included in this document for context. New policy language has been underlined and deleted language has been struck-through to highlight proposed policy changes.

Note: The current language regarding the Screening and Diagnostic Studies of the Breast benefit can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, Section 9.2.15.4 Mammography (Screening and Diagnostic Studies of the Breast).

Texas Medicaid

SCREENING AND DIAGNOSTIC STUDIES OF THE BREAST

Statement of Benefits

1 The following breast imaging studies are a benefit of Texas Medicaid:
   1.1 Screening mammogram
   1.2 Diagnostic mammogram
   1.3 Diagnostic breast ultrasound

Screening Mammogram

2 A screening mammogram is an X-ray of the breast used to detect breast changes in women who have no signs or symptoms of breast cancer. The American Cancer Society recommends that women discuss when to start breast cancer screening mammography with their providers beginning at 40 years of age.
   2.1 By age 45, all women should begin annual breast cancer mammography screening.
   2.2 At age 55, women may transition to screening with mammography every other year, or in some cases may continue annual screenings in consultation with their healthcare provider.
Digital breast tomosynthesis (DBT), also known as 3D mammography, provides three-dimensional images and is a modification of conventional mammography. Screening DBT is used, along with conventional screening mammography, to detect breast changes in women who have no signs or symptoms of breast cancer.

**Diagnostic Mammogram**

A diagnostic mammogram is used to diagnose breast disease in those women or men who have breast symptoms or findings on physical examination or screening mammogram.

Diagnostic DBT is used, along with conventional diagnostic mammography, to diagnose breast disease in those women or men who have breast symptoms or findings on physical examination or screening mammogram.

**Diagnostic Breast Ultrasound**

Ultrasound is used to evaluate breast abnormalities that are found with screening or diagnostic mammography.

**Authorization Requirements**

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client’s medical record.

The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician. Additional studies are studies done in addition to screening mammograms and include diagnostic mammograms using procedure codes 4/I/T-77065, 4/I/T-77066, and computer-aided detection (CAD) using procedure code 4/I/T-77067.

**Reimbursement**

**Screening Mammogram**

The following procedure codes will be considered for reimbursement for screening mammography:

<table>
<thead>
<tr>
<th>Procedure Code</th>
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</thead>
<tbody>
<tr>
<td>4/I/T-77063</td>
</tr>
<tr>
<td>4/I/T-77067</td>
</tr>
</tbody>
</table>

Procedure code 4/I/T-77063 must be billed with primary code 4/I/T-77067. Reimbursement may be considered for procedure code 4/I/T-77063 when performed on the same day, any provider, as procedure code 4/I/T-77067.

Procedure codes 4/I/T-77063 and 4/I/T-77067 are limited to one per rolling year, any provider.
Diagnostic Mammogram

The following procedure codes may be considered for reimbursement for diagnostic mammography:

Table B: Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
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</thead>
<tbody>
<tr>
<td>4/I/T-77065</td>
</tr>
<tr>
<td>4/I/T-77066</td>
</tr>
<tr>
<td>4/I/T-G0279</td>
</tr>
</tbody>
</table>

Procedure code 4/I/T-77065 will be denied when billed on the same day, any provider, as procedure code 4/I/T-77066.

Procedure code 4/I/T-G0279 must be billed with primary code 4/I/T-77065 or 4/I/T-77066. Reimbursement may be considered for procedure code 4/I/T-G0279 when performed on the same day, any provider, as procedure codes 4/I/T-77065 or 4/I/T-77066.

Reimbursement may be considered for a screening mammogram (procedure code 4/I/T-77063 or 4/I/T-77067) performed on the same patient on the same day as a diagnostic mammogram (procedure code 4/I/T-77065, 4/I/T-77066, or 4/I/T-G0279) by submitting the diagnostic mammography code with the modifier GG.

The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician. Additional studies are studies done in addition to screening mammograms and include diagnostic mammograms using procedure codes 4/I/T-77065, 4/I/T-77066, 4/I/T-G0279 and computer-aided detection (CAD) using procedure code 4/I/T-77067.

A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 4/I/T-77065, 4/I/T-77066, and 4/I/T-G0279 may be considered for reimbursement.
Diagnostic Procedures

18 Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement.

Table C: Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
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<tbody>
<tr>
<td>4/I/T-76098</td>
</tr>
<tr>
<td>4/I/T-77053</td>
</tr>
<tr>
<td>4/I/T-77054</td>
</tr>
</tbody>
</table>

19 Procedure code 4/I/T-77053 will be denied when billed on the same day, any provider, as procedure code 4/I/T-77054.

Breast Ultrasound

20 Ultrasound may be considered for reimbursement using one of the following procedure codes:

Table D: Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
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</thead>
<tbody>
<tr>
<td>4/I/T-76641</td>
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<tr>
<td>4/I/T-76642</td>
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