Priority Health	BILLING POLICY No. 180
Mammography & Tomosynthesis Billing Policy	
Date of origin: Feb. 24, 2026	**Review dates: 02/2026**

DEFINITION

This policy identifies billing and payment requirements associated with Mammography and Tomosynthesis.

Definitions

A diagnostic mammogram is a radiologic service performed for individuals who have signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-confirmed benign breast conditions. This service includes a physician's interpretation of the imaging results.

A screening mammogram is a radiologic service performed for women who have no signs or symptoms of breast disease, with the goal of detecting breast cancer at an early stage. This service includes a physician's interpretation of the imaging results. A screening mammogram has defined technical requirements and must include, at minimum, two standard views of each breast: the cranio-caudal (CC) view and the mediolateral oblique (MLO) view.

Tomosynthesis is a 3D mammography procedure that can be used for screening or diagnostics.

MEDICAL POLICY

- *No current PH Medical Policy*

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

A diagnostic mammography is a covered service if it is ordered by a doctor of medicine or osteopathy.

A mammogram is not payable if performed on a woman under age 35. Payment may be made for only one screening mammogram performed on a woman over age 34, but under age 40. For an asymptomatic woman over age 39, a screening mammography is payable if 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 when the following criteria is met:

- A patient has specific signs and symptoms for which warrant a mammogram;
- A patient has a documented history of breast cancer; or
- A patient is asymptomatic but, based on the patient's medical 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 have had the disease, is considered medically appropriate, but excluded for Medicare payment.

Coding specifics

- *With Type of Bill 12, 13, 22, 23, and 85: Codes 77063 and 77067 should be billed with REV code 403.*
- *Codes 77061, 77062, 77065 and 77066 should be billed with REV code 401.*

Resources

- *CMS NCD 220.4- Mammograms*
- *RadiologyInfo.org- Tomosynthesis*

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made