

Screening vs Diagnostic Mammogram

Understanding the bill for your procedure

Screening mammography is used to detect breast changes in women who have no signs or symptoms or observable breast abnormalities, and no personal history of breast cancer.

Diagnostic mammography is used to investigate suspicious breast changes such as lumps, pain, unusual skin appearance, nipple thickening, or nipple discharge. It also is used to evaluate abnormal findings from a screening mammogram. It also is used if you have had a personal history of breast cancer.

You should not have a **screening** mammogram if:

- It has been less than 12 months from your previous mammogram
- You are younger than 35, unless you have an immediate relative, such as a mother or sister, with breast cancer diagnosed before the age of 45. This requires a written order from your physician.
- You are pregnant
- You are breast feeding
- You have had a personal history of breast cancer.

A small percentage of screening mammogram patients will have a questionable finding that will require further testing, such as special mammographic images, breast ultrasound or a breast biopsy. If additional testing is needed, the patient may incur additional out of pocket expenses.

Insurance coverage - We advise you to contact your insurance company prior to the scheduled appointment. Mammography coverage varies from one insurance plan to another, and can change annually. Depending on your insurance coverage, you may be responsible for facility and radiologist fees.

Expect to receive up to three bills for these tests:

- Facility fee
- Physician services
- Pathology

Billing - We make every effort to code correctly for your procedure with the correct modifiers and diagnoses. The correct coding of a procedure is driven by the physician documentation and your medical history. It is not dictated by your insurance benefit or your insurance company.