

Ultrasound Breast Biopsy

2010 CODING & REIMBURSEMENT GUIDE

Ultrasound Biopsy

Breast Biopsy

CPT® CODE ¹	DESCRIPTION	LOCATION	2010 NATIONAL PAYMENT AVERAGE ^{2,3}
19102	Percutaneous, needle core biopsy using imaging guidance	Office - Global	\$204.86
		Professional - Hosp/ASC	\$103.15
		Facility - Hospital	\$526.74
		Facility - ASC	\$292.19
19103	Percutaneous, automated vacuum assisted or rotating biopsy using imaging guidance	Office - Global	\$518.28
		Professional - Hosp/ASC	\$191.51
		Facility - Hospital	\$1044.81
		Facility - ASC	\$560.36
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy	Office - Global	\$84.04
		Professional - Hosp/ASC	Packaged
		Facility - Hospital	Packaged
		Facility - ASC	Packaged
76098	Radiological examination, surgical specimen	Office - Global	\$19.12
		Professional - Hospital	\$8.30
		Facility - Hospital	\$10.82
76645	Ultrasound breast(s) (unilateral or bilateral), real time with image documentation	Office - Global	\$89.81
		Professional - Hospital	\$27.41
		Facility - Hospital	\$62.40
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	Office - Global	\$181.78
		Professional - Hospital	\$33.90
		Facility - Hospital	\$147.87
77055	Mammography, unilateral	Office - Global	\$82.59
		Professional - Hospital	\$35.35
		Facility - Hospital	\$47.25
77056	Mammography, both breasts	Office - Global	\$105.31
		Professional - Hospital	\$44.00
		Facility - Hospital	\$61.31

Place of Service⁴

PLACE OF SERVICE CODE	PLACE OF SERVICE NAME	PLACE OF SERVICE DESCRIPTION
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
24	Ambulatory Surgery Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis

1. American Medical Association, CPT® 2007, Professional Edition and HCPCS 2007, Nineteenth edition.

2. Refer to information concerning status indicator taken from the Medicare 2010 Outpatient Final Rule, published in the Federal Register, November 25, 2009.

3. Physician relative value units (RVUs) are based on the Medicare 2010 Physician Fee Schedule Final Rule published in the Federal Register, November 25, 2009. National average Medicare rates, rounded to the nearest dollar, are based on these RVUs and account for the work RVU adjustment completed by CMS for Medicare budget neutrality purposes. The 2010 conversion factor is \$36.067. Actual payment to a physician will vary based on geographic location. Payment for a given procedure in a given locality is available in the Medicare Physician Fee Schedule Look-up file posted in the Physician Center of the CMS website. The 2010 payment rates could be further revised if Congress were to enact legislation that would revise the conversion factor, which has typically occurred in recent years.

4. Place of service codes listed in CPT® 2007, Current Procedural Terminology, Professional Edition, 2006 American Medical Association.

Current Procedural Terminology (CPT) is copyright 2006 American Medical Association. All Rights Reserved. CPT® is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS Restrictions Apply for Government Use.

Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which CPT®/HCPCS codes and modifiers to use for a particular service, supply, procedure or treatment. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Contact your local carrier and payer organizations for specific coding guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide. Any payment rates listed are Medicare averages that may be subject to change without notice. Reimbursement may differ based on geographic regional variance and/or policies and fee schedules outlined as terms in your health plan, payer and/or carrier contracts.