Breast Imaging

Global, Professional and Technical Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2016 National Average Medicare Rate[3]
Analog (Film) Mammography				
77055	Mammography; unilateral	Office/Freestanding (Global)	2.52	$90.23
		Facility (Professional)	1.00	$35.80
		Facility (Technical)	1.52	$54.42
77056	Mammography; bilateral	Office/Freestanding (Global)	3.24	$116.01
		Facility (Professional)	1.24	$44.40
		Facility (Technical)	2.00	$71.61
77057	Screening mammography, bilateral (2-view film study of each breast)	Office/Freestanding (Global)	2.31	$82.71
		Facility (Professional)	1.00	$35.80
		Facility (Technical)	1.31	$46.90

Digital Mammography Providers should continue to bill for digital mammography and breast tomosynthesis using existing G-codes

Screening Breast Tomosynthesis (Bilateral)				
G0202	Screening mammography, producing direct digital image, bilateral, all views	Office/Freestanding (Global)	3.77	$135.98
		Facility (Professional)	0.99	$35.45
		Facility (Technical)	2.78	$99.54
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	1.56	$55.85
		Facility (Professional)	0.85	$30.43
		Facility (Technical)	0.71	$25.42
Diagnostic Breast Tomosynthesis (Unilateral)				
G0206	Diagnostic mammography, producing direct digital 2-D image, unilateral, all views	Office/Freestanding (Global)	3.62	$129.61
		Facility (Professional)	0.99	$35.45
		Facility (Technical)	2.63	$94.17
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 and G0206)	Office/Freestanding (Global)	1.56	$55.85
		Facility (Professional)	0.85	$30.43
		Facility (Technical)	0.71	$25.42
Diagnostic Breast Tomosynthesis (Bilateral)				
G0204	Diagnostic mammography, producing direct digital 2-D image, bilateral, all views	Office/Freestanding (Global)	4.61	$165.06
		Facility (Professional)	1.24	$44.40
		Facility (Technical)	3.37	$120.66
G0279	Diagnostic digital breast, tomosynthesis, unilateral or bilateral (List separately in addition to G0204 and G0206)	Office/Freestanding (Global)	1.56	$55.85
		Facility (Professional)	0.85	$30.43
		Facility (Technical)	0.71	$25.42

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2. The 2016 physician relative value units (RVUs) are from the 2016 RVU file available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending as of January 21, 2016.
3. The national average 2016 Medicare rates to physicians shown are based on the 2016 conversion factor of $35.8043 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2016 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

Breast Imaging

Global, Professional and Technical Payment

CPT® Code[1]	Description	Site of Service Component	RVU or APC[2]	2016 National Average Medicare Rate[3]
Computer-Aided Detection (CAD) When CAD is utilized with mammography, it should be reported separately with one of the following add-on codes in addition to the primary procedure (i.e., G0202, G0204, or G0206)				
77051	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	0.23	$8.23
		Facility (Professional)	0.08	$2.86
		Facility (Technical)	0.15	$5.37
77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	0.23	$8.23
		Facility (Professional)	0.08	$2.86
		Facility (Technical)	0.15	$5.37
Breast Ultrasound Effective January 1, 2015, two new codes were issued for billing Breast Ultrasound, replacing CPT 76645, which has been deleted. CPT 76641 represents a complete ultrasound examination consisting of all four quadrants of the breast and the retroareolar region, including examination of the axilla if performed. CPT 76642 represents a focused ultrasound examination of one or more, but not all four quadrants, and includes examination of the axilla if performed. CPT 76641 and 76642 are unilateral ultrasound examinations. If breast ultrasound is performed bilaterally with either code, it should be billed using a bilateral payment indicator, and will be paid at 150% of the unilateral payment				
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Office/Freestanding (Global)	3.04	$108.85
		Facility (Professional)	1.04	$37.24
		Facility (Technical) (Hospital Outpatient)	APC 5531 with status indicator Q1[4]	$92.07
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Office/Freestanding (Global)	2.50	$89.51
		Hospital	0.98	$34.73
		Facility (Technical) (Hospital Outpatient)	APC 5531 with status indicator Q1[4]	$92.07

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2. The 2016 physician relative value units (RVUs) are from the 2016 RVU file available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending as of January 21, 2016. 2016 Ambulatory Payment Classifications (APCs) are from the 2016 Hospital Outpatient Prospective Payment System (OPPS), January 2016, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.
3. The national average 2016 Medicare rates to physicians are based on the 2016 conversion factor of $35.8043. Medicare payment for a given procedure in a given locality in 2016 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. The national average 2016 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2016, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The payment rate for HCPCS code Q9967 is available in the Average Sales Price files. The rate provided in this document is for October 1, 2015 through December 31, 2015 Average Sales Price (ASP) Drug Pricing Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a physician, hospital, or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
4. Status indicator "Q1" means payment is packaged if billed on the same date of service as a HCPCS code assigned status indicator "S", "T", or "V"; otherwise payment is made through a separate APC payment.

Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which 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 payer for specific coding and coverage guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide.

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