Extremity Imaging

Global and Physician Professional Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2017 National Average Medicare Rate[3]
Fluoroscopy				
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)	Office/Freestanding (Global)	1.34	$48.09
		Facility (Professional)	0.25	$8.97
		Facility (Technical)	1.09	$39.12
76001	Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (e.g., nephrostolithomtomy, ERCP, bronchoscopy, transbronchial biopsy)	Office/Freestanding (Global)	NA	Determined by Contractors
		Facility (Professional)	1.04	$37.32
		Facility (Technical)	NA	Determined by Contractors
Fluoroscopic Guidance				
77002	Fluoroscopic guidance for all types of needle placement (eg, biopsy, aspiration, injection, or localization device)	Office/Freestanding (Global)	2.63	$94.39
		Facility (Professional)	0.80	$28.71
		Facility (Technical)	1.83	$65.68
Radiologic Examination				
73030	Radiologic examination, shoulder, minimum of 2 views	Office/Freestanding (Global)	0.82	$29.43
		Facility (Professional)	0.27	$9.67
		Facility (Technical)	0.55	$19.74
73100	Radiologic examination, wrist; 2 views	Office/Freestanding (Global)	0.82	$29.43
		Facility (Professional)	0.24	$8.61
		Facility (Technical)	0.58	$20.82
73110	Radiologic examination, wrist, complete, minimum of 3 views	Office/Freestanding (Global)	1.00	$35.89
		Facility (Professional)	0.25	$8.97
		Facility (Technical)	0.75	$26.92
73120	Radiologic examination, hand, 2 views	Office/Freestanding (Global)	0.74	$26.56
		Facility (Professional)	0.24	$8.61
		Facility (Technical)	0.50	$17.94
73130	Radiologic examination, hand, minimum of 3 views	Office/Freestanding (Global)	0.87	$31.22
		Facility (Professional)	0.25	$8.61
		Facility (Technical)	0.62	$22.25

Additional Information:

1. Fluoroscopy reported as CPT Codes 76000 or 76001 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and should not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.
2. Fluoroscopic guidance reported as CPT 77002 is considered "bundled" with certain arthrography supervision and interpretation services (i.e., CPT Codes 73085, 73115, 73580 and 73615). NCCI Procedure-to-Procedure (PTP) edits can be found on the CMS website: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

1. American Medical Association (AMA), 2017 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2016 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2017 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
2. The 2017 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 April 19, 2017.
3. The national average 2016 Medicare rates to physicians shown are based on the 2017 conversion factor of $35.8887 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2017 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.

Extremity Imaging

Global and Physician Professional Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2017 National Average Medicare Rate[3]
Radiologic Examination				
73140	Radiologic examination, finger or fingers, minimum of 2 views	Office/Freestanding (Global)	0.89	$31.94
		Facility (Professional)	0.20	$7.18
		Facility (Technical)	0.69	$24.76
73560	Radiologic examination, knee, 1 or 2 views	Office/Freestanding (Global)	0.87	$31.22
		Facility (Professional)	0.24	$8.61
		Facility (Technical)	0.63	$22.61
73600	Radiologic examination, ankle, 2 views	Office/Freestanding (Global)	0.84	$30.15
		Facility (Professional)	0.24	$8.61
		Facility (Technical)	0.60	$21.53
73610	Radiologic examination, ankle, complete, minimum of 3 views	Office/Freestanding (Global)	0.89	$31.94
		Facility (Professional)	0.25	$8.97
		Facility (Technical)	0.64	$22.97
Bone / Joint Studies				
77071	Manual application of stress performed by physician or other health care professional for joint radiography, including contralateral joint if indicated	Office/Freestanding (Global)	1.37	$49.17
		Facility (Professional)	NA	NA
		Facility (Technical)	NA	NA
77077	Joint survey, single view, 2 or more joints (specify)	Office/Freestanding (Global)	1.05	$37.68
		Facility (Professional)	0.46	$16.51
		Facility (Technical)	0.59	$21.17

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Extremity Imaging

Facility Payment

CPT® Code[1]	Description	Site of Service Component	APC[2]	Status Indicator (SI)[2]	2017 National Average Medicare Rate[2]
Fluoroscopy					
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)	Hospital	5523	S	$225.91
		ASC	NA	Z3	$38.76
76001	Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (e.g., nephrostolithomtomy, ERCP, bronchoscopy, transbronchial biopsy)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Fluoroscopic Guidance					
77002	Fluoroscopic guidance for all types of needle placement (e.g., biopsy, aspiration, injection, or localization device)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Radiologic Examination					
73030	Radiologic examination, shoulder, minimum of 2 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73100	Radiologic examination, wrist; 2 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73110	Radiologic examination, wrist, complete, minimum of 3 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73120	Radiologic examination, hand, 2 views	Hospital	5522	Q1	$112.73
		ASC	NA	N1	Packaged
73130	Radiologic examination, hand, minimum of 3 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73140	Radiologic examination, finger or fingers, minimum of 2 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged

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2. The national average 2017 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, April 2017, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.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 hospital 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.

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Extremity Imaging
Facility Payment

CPT® Code[1]	Description	Site of Service Component	APC[2]	Status Indicator (SI)[2]	2017 National Average Medicare Rate[2]
Radiologic Examination					
73560	Radiologic examination, knee, 1 or 2 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73600	Radiologic examination, ankle, 2 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
73610	Radiologic examination, ankle, complete, minimum of 3 views	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
Bone / Joint Studies					
77071	Manual application of stress performed by physician or other health care professional for joint radiography, including contralateral joint if indicated	Hospital	5521	Q1	$59.86
		ASC	NA	N1	Packaged
77077	Joint survey, single view, 2 or more joints (specify)	Hospital	5522	Q1	$112.73
		ASC	NA	N1	Packaged

Status Indicator Information[2]

Status Indicator (SI)	Explanation
Q1	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
S	Significant procedure not subject to multiple procedure discount
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
Payment Indicator (PI)	**Explanation**
N1	Service is packaged into payment for other services; no separate ASC payment
Z3	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility Practice Expense RVUsDE

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hologic.com | Hologic@thepinnaclehealthgroup.com | 1.866.369.9290