Breast Imaging

Global, Professional and Technical Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2017 National Average Medicare Rate[3]
Mammography Providers should bill for mammography and breast tomosynthesis using G-codes				
Screening Breast Tomosynthesis (Bilateral)				
G0202	Screening mammography, producing direct digital image, bilateral, all views	Office/Freestanding (Global)	3.85	$138.17
		Facility (Professional)	1.05	$37.68
		Facility (Technical)	2.80	$100.49
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	1.57	$56.35
		Facility (Professional)	0.86	$30.86
		Facility (Technical)	0.71	$25.48
Diagnostic Breast Tomosynthesis (Unilateral)				
G0206	Diagnostic mammography, producing direct digital 2-D image, unilateral, all views	Office/Freestanding (Global)	3.76	$134.94
		Facility (Professional)	1.11	$39.84
		Facility (Technical)	2.65	$95.11
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 and G0206)	Office/Freestanding (Global)	1.57	$56.35
		Facility (Professional)	0.86	$30.86
		Facility (Technical)	0.71	$25.48
Diagnostic Breast Tomosynthesis (Bilateral)				
G0204	Diagnostic mammography, producing direct digital 2-D image, bilateral, all views	Office/Freestanding (Global)	4.77	$171.19
		Facility (Professional)	1.38	$49.53
		Facility (Technical)	3.39	$121.66
G0279	Diagnostic digital breast, tomosynthesis, unilateral or bilateral (List separately in addition to G0204 and G0206)	Office/Freestanding (Global)	1.57	$56.35
		Facility (Professional)	0.86	$30.86
		Facility (Technical)	0.71	$25.48

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 2017 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 2017 Medicare rates to physicians shown are based on the 2016 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.

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CPT® Code[1]	Description	Site of Service Component	RVU or APC[2]	2017 National Average Medicare Rate[3]
Potential Codes for Contrast-Enhanced Mammography When contrast is utilized with mammography, it could be reported with either (1) 96374 and Q9967 in addition to the primary procedure code (i.e., G0204 or G0206)[4], or (2) 76499 and Q9967 without a code for a mammography procedure				
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Office/Freestanding (Global)	1.62	$58.14
		Facility (Professional)	NA	NA
		Facility (Technical) (Hospital Outpatient)	APC 5693 with status indicator S[5]	$179.77
76499	Unlisted diagnostic radiographic procedure	Office/Freestanding (Global)	NA	Determined by contractors
		Facility (Professional)	NA	Determined by contractors
		Facility (Technical)	APC 5521 with status indicator Q1[6]	$59.86
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Office/Freestanding (Global)	NA	$0.127/ml
		Facility (Professional)	NA	NA
		Facility (Technical)	Packaged	
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)	3.05	$109.46
		Facility (Professional)	1.04	$37.32
		Facility (Technical) (Hospital Outpatient)	APC 5522 with status indicator Q1[6]	$112.73
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Office/Freestanding (Global)	2.51	$90.08
		Hospital	0.97	$34.81
		Facility (Technical) (Hospital Outpatient)	APC 5521 with status indicator Q1[6]	$59.86

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2. The 2017 physician relative value units (RVUs) are from the 2017 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. 2017 Ambulatory Payment Classifications (APCs) are from the 2017 Hospital Outpatient Prospective Payment System (OPPS), January 2017, 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 2017 Medicare rates to physicians are based on the 2017 conversion factor of $35.8887. 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. 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. The payment rate for HCPCS code Q9967 is available in the Average Sales Price files. The payment rate for HCPCS code Q9967 is available in the Average Sales Price files. The rate provided in this document is for April 1, 2017 - June 30, 2017 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. CPT 2017, Professional Edition, advises, "Do not report 96365-96479 with codes for which IV push or infusion is an inherent part of the procedure (e.g., administration of contrast material for a diagnostic imaging study)." Because IV push or infusion is not an inherent part of digital mammography services, it could be appropriate to report this service in addition to a digital mammography code. Consult your payer for its instructions on how to bill for contrast-enhanced mammography.
5. Status indicator "S" means procedure is significant and not subject to multiple procedure discount.
6. 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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