Breast Imaging: Mammography

Global, Professional and Technical Payment

CPT® Code[1,2]	Description	Place-of-Service Component	RVU[3]	2021 National Average Medicare Rate[4]
Screening Breast Tomosynthesis (Bilateral)				
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Global (Office/Freestanding)	3.85	$134.34
		Professional (Facility)	1.08	$37.68
		Technical (Facility)	2.77	$96.65
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Global (Office/Freestanding)	1.59	$55.48
		Professional (Facility)	0.86	$30.01
		Technical (Facility)	0.73	$25.47
Diagnostic Breast Tomosynthesis (Unilateral)				
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global (Office/Freestanding)	3.76	$131.20
		Professional (Facility)	1.14	$39.78
		Technical (Facility)	2.62	$91.42
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Global (Office/Freestanding)	1.59	$55.48
		Professional (Facility)	0.86	$30.01
		Technical (Facility)	0.73	$25.47
Diagnostic Breast Tomosynthesis (Bilateral)				
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global (Office/Freestanding)	4.76	$166.09
		Professional (Facility)	1.41	$49.20
		Technical (Facility)	3.35	$116.89
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Global (Office/Freestanding)	1.59	$55.48
		Professional (Facility)	0.86	$30.01
		Technical (Facility)	0.73	$25.47

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2. Centers for Medicare & Medicaid Services (CMS), 2021 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
3. The 2021 physician relative value units (RVUs) are from the 2021 Physician Fee Schedule (PFS) Final Rule, Addendum B available on the CMS website at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.
4. The national average 2021 Medicare rates to physicians shown are based on the 2021 conversion factor of $34.8931 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2021 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://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: Contrast-Enhanced Mammography

Global, Professional and Technical Payment

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., 77066 or 77065)[5], or (2) 76499 and Q9967 without a code for a mammography procedure

CPT® Code[1,2]	Description	Place-of-Service Component	RVU[3] or APC[4]	2021 National Average Medicare Rate[5]
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	1.20	$41.87
		Professional (Facility)	NA	NA
		Technical (Facility)	APC 5693 with status indicator S[7]	$203.50
76499	Unlisted diagnostic radiographic procedure	Global (Office/Freestanding)	NA	Determined by contractors
		Professional (Facility)	NA	Determined by contractors
		Technical (Facility)	APC 5521 with status indicator Q1[8]	$80.90
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Global (Office/Freestanding)	NA	$0.114/ml
		Professional (Facility)	NA	NA
		Technical (Facility)	NA	

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2. Centers for Medicare & Medicaid Services (CMS), 2021 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
3. The 2021 physician relative value units (RVUs) are from the 2021 Physician Fee Schedule (PFS) Final Rule, Addendum B available on the CMS website at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.
4. The national average 2021 Medicare rates and status indicators for the hospital outpatient setting are from the 2021 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addenda B and D1, accessible at https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc. The national average 2021 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2021 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1736-fc. 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 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. January 2021 ASP Pricing File, available at https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2021-asp-drug-pricing-files.
5. The national average 2021 Medicare rates to physicians shown are based on the 2021 conversion factor of $34.8931 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2021 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://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
6. CPT 2021, 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.
7. Status indicator "S" means procedure is significant and not subject to multiple procedure discount.
8. 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.

Breast Imaging: Breast Ultrasound

Global, Professional and Technical Payment

CPT® Code[1,2]	Description	Place-of-Service Component	RVU[2] or APC[3]	2021 National Average Medicare Rate[4]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Global (Office/Freestanding)	3.12	$108.87
		Professional (Facility)	1.03	$35.94
		Technical (Facility)	APC 5522 with status indicator Q1[5]	$108.97
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Global (Office/Freestanding)	2.57	$89.68
		Professional (Facility)	0.97	$33.85
		Technical (Facility)	APC 5521 with status indicator Q1[5]	$80.90
Elastography				
76981	Ultrasound, elastography; parenchyma (eg, organ)	Global (Office/Freestanding)	3.14	$109.56
		Professional (Facility)	0.84	$29.31
		Hospital Outpatient	APC 5522 with status indicator Q3[6]	$108.97
76982	Ultrasound, elastography; first target lesion	Global (Office/Freestanding)	2.92	$101.89
		Professional (Facility)	0.85	$29.66
		Hospital Outpatient	APC 5522 with status indicator Q3[6]	$108.97
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Global (Office/Freestanding)	1.83	$63.85
		Professional (Facility)	0.72	$25.12
		Hospital Outpatient	APC NA with status indicator N[7]	$0.00

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2. The 2021 physician relative value units (RVUs) are from the 2021 Physician Fee Schedule (PFS) Final Rule, Addendum B available on the CMS website at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.
3. The national average 2021 Medicare rates and status indicators for the hospital outpatient setting are from the 2021 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addenda B and D1, accessible at https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc. The national average 2021 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2021 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1736-fc. 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 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. The national average 2021 Medicare rates to physicians shown are based on the 2021 conversion factor of $34.8931 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2021 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://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
5. 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.
6. Status indicator "Q3" means the code is subject to payment as part of a composite APC. Codes subject to payment as part of a composite are packaged into the composite rate when all criteria for that composite are met. Otherwise, Q3 status indicator services may become separately payable, if assigned to a separate APC, or packaged into other services if not assigned to a separate APC.
7. Status indicator "N" means payment is packaged into payment for other services. Therefore there is no separate APC payment.

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