# Breast Imaging: Mammography

## Global, Professional and Technical Payment

| CPT® Code[1,2] | Description | Place-of-Service | RVU[3] | 2022 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) | 3.83 | $128.68 |
| | | Professional (Facility/Non-Facility) | 1.07 | $35.95 |
| | | Technical (Facility) | 2.76 | $92.73 |
| 77063 | Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure) | Global (Office/Freestanding) | 1.56 | $52.41 |
| | | Professional (Facility/Non-Facility) | 0.86 | $28.89 |
| | | Technical (Facility) | 0.70 | $23.52 |
| **Diagnostic Breast Tomosynthesis (Unilateral)** | | | | |
| 77065 | Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral | Global (Office/Freestanding) | 3.76 | $126.33 |
| | | Professional (Facility/Non-Facility) | 1.14 | $38.30 |
| | | Technical (Facility) | 2.62 | $88.03 |
| G0279 | Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066) | Global (Office/Freestanding) | 1.56 | $52.41 |
| | | Professional (Facility/Non-Facility) | 0.86 | $28.89 |
| | | Technical (Facility) | 0.70 | $23.52 |
| **Diagnostic Breast Tomosynthesis (Bilateral)** | | | | |
| 77066 | Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral | Global (Office/Freestanding) | 4.75 | $159.59 |
| | | Professional (Facility/Non-Facility) | 1.41 | $47.37 |
| | | Technical (Facility) | 3.34 | $112.22 |
| G0279 | Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066) | Global (Office/Freestanding) | 1.56 | $52.41 |
| | | Professional (Facility/Non-Facility) | 0.86 | $28.89 |
| | | Technical (Facility) | 0.70 | $23.52 |

Payment for screening and diagnostic mammography services is provided under the Medicare physician fee schedule (MPFS) when furnished in hospitals, skilled nursing facilities, and critical access hospitals not electing the optional method of payment for outpatient services. Medicare Claims Processing Manual, Ch. 4, 10.6.2.2, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf.

1. American Medical Association (AMA), 2022 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2021 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.
2. Centers for Medicare & Medicaid Services (CMS), 2022 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update
3. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Final Rule, Addendum B available on the CMS website at https://www.cms.gov/files/zip/cy-2022-pfs-final-rule-addenda.zip [cms.gov].
4. The national average 2022 Medicare rates to physicians shown are based on the 2022 conversion factor of $33.5983 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2022 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.

**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.**

# Breast Imaging: Contrast-Enhanced Mammography

## Global and Physician Professional 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)[6], or (2) 76499 and Q9967 without a code for a mammography procedure

| CPT® Code[1] / HCPCS Code[2] | Description | Place-of-Service | RVU[3] | 2022 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) | 1.16 | $38.97 |
| | | Professional (Facility) | NA | NA |
| 76499 | Unlisted diagnostic radiographic procedure | Global (Office/Freestanding) | NA | Determined by contractors |
| | | Professional (Facility) | NA | Determined by contractors |
| Q9967 | Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml | Global (Office/Freestanding) | NA | $0.123/ml |
| | | Professional (Facility) | NA | NA |

## Facility 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)[6], or (2) 76499 and Q9967 without a code for a mammography procedure

| CPT® Code[1] / HCPCS Code[2] | Description | Place-of-Service | APC[4] | Status Indicator | 2022 National Average Medicare Rate[4] |
|---|---|---|---|---|---|
| 96374 | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug | Hospital | 5693 | S[7] | $208.93 |
| 76499 | Unlisted diagnostic radiographic procedure | Hospital | 5521 | Q1[8] | $82.61 |
| Q9967 | Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml | Hospital | NA | NA | NA |

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2. Centers for Medicare & Medicaid Services (CMS), 2022 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCSQuarterly-Update
3. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Final Rule, Addendum B available on the CMS website at https://www.cms.gov/files/zip/cy-2022-pfs-final-rule-addenda.zip [cms.gov].
4. The national average 2022 Medicare rates and status indicators for the hospital outpatient setting are from the 2022 Hospital Outpatient Prospective Payment System (OPPS) release, Addenda B, and D1 accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip [cms.gov]. 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.
5. The national average 2022 Medicare rates to physicians shown are based on the 2022 conversion factor of $33.5983 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2022 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. The national average Medicare rate for Q9967 comes from the October 2021 ASP Pricing File, available at https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2021-asp-drug-pricing-files.
6. CPT 2022, 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.

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**hologic.com | Hologic@thepinnaclehealthgroup.com | 1.866.369.9290**

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