Extremity Imaging

Global and Physician Professional Payment

CPT® Code[1]	Description	Place-of-Service	RVU[2]	2022 National Average Medicare Rate[3]
Fluoroscopy				
76000[i]	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	Global (Office/Freestanding)	1.28	$43.01
		Professional (Facility/Non-Facility)	0.45	$15.12
		Technical (Non-Facility)	0.83	$27.89
Fluoroscopic Guidance				
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	Global (Office/Freestanding)	3.49	$117.26
		Professional (Facility/Non-Facility)	0.80	$26.88
		Technical (Non-Facility)	2.69	$90.38
Radiologic Examination				
73030	Radiologic examination, shoulder; complete, minimum of 2 views	Global (Office/Freestanding)	1.03	$34.61
		Professional (Facility/Non-Facility)	0.27	$9.07
		Technical (Non-Facility)	0.76	$25.53
73100	Radiologic examination, wrist; 2 views	Global (Office/Freestanding)	1.01	$33.93
		Professional (Facility/Non-Facility)	0.24	$8.06
		Technical (Non-Facility)	0.77	$25.87
73110	Radiologic examination, wrist, complete, minimum of 3 views	Global (Office/Freestanding)	1.22	$40.99
		Professional (Facility/Non-Facility)	0.25	$8.40
		Technical (Non-Facility)	0.97	$32.59
73120	Radiologic examination, hand, 2 views	Global (Office/Freestanding)	0.93	$31.25
		Professional (Facility/Non-Facility)	0.24	$8.06
		Technical (Non-Facility)	0.69	$23.18
73130	Radiologic examination, hand, minimum of 3 views	Global (Office/Freestanding)	1.09	$36.62
		Professional (Facility/Non-Facility)	0.25	$8.40
		Technical (Non-Facility)	0.84	$28.22

Additional Information:

i Fluoroscopy reported as CPT Codes 76000 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.

ii 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), 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. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Final Rule, Addendum B available from the CMS website at https://www.cms.gov/files/zip/cy-2022-pfs-final-rule-addenda.zip [cms.gov].
3. 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.

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CPT® Code[1]	Description	Place-of-Service	RVU[2]	2022 National Average Medicare Rate[3]
Radiologic Examination				
73140	Radiologic examination, finger or fingers, minimum of 2 views	Global (Office/Freestanding)	1.12	$37.63
		Professional (Facility/Non-Facility)	0.20	$6.72
		Technical (Non-Facility)	0.92	$30.91
73560	Radiologic examination, knee, 1 or 2 views	Global (Office/Freestanding)	1.02	$34.27
		Professional (Facility/Non-Facility)	0.24	$8.06
		Technical (Non-Facility)	0.78	$26.21
73600	Radiologic examination, ankle, 2 views	Global (Office/Freestanding)	0.96	$32.25
		Professional (Facility/Non-Facility)	0.23	$7.73
		Technical (Non-Facility)	0.73	$24.53
73610	Radiologic examination, ankle, complete, minimum of 3 views	Global (Office/Freestanding)	1.10	$36.96
		Professional (Facility/Non-Facility)	0.25	$8.40
		Technical (Non-Facility)	0.85	$28.56
Bone / Joint Studies				
77071	Manual application of stress performed by physician or other qualified health care professional for joint radiography, including contralateral joint if indicated	Global (Office/Freestanding)	1.65	$55.44
		Professional (Facility/Non-Facility)	1.65	$55.44
		Technical (Non-Facility)	NA	NA
77077	Joint survey, single view, 2 or more joints (specify)	Global (Office/Freestanding)	1.40	$47.04
		Professional (Facility/Non-Facility)	0.49	$16.46
		Technical (Non-Facility)	0.91	$30.57

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3. 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.

Extremity Imaging

Facility Payment

CPT® Code[1]	Description	Place-of-Service	APC[2]	Status Indicator (SI)[2]	2022 National Average Medicare Rate[2]
Fluoroscopy					
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	Hospital	5523	S	$235.00
		ASC	NA	Z3	$27.55
Fluoroscopic Guidance					
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Radiologic Examination					
73030	Radiologic examination, shoulder; complete, minimum of 2 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73100	Radiologic examination, wrist; 2 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73110	Radiologic examination, wrist, complete, minimum of 3 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73120	Radiologic examination, hand, 2 views	Hospital	5522	Q1	$111.19
		ASC	NA	N1	Packaged
73130	Radiologic examination, hand, minimum of 3 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73140	Radiologic examination, finger or fingers, minimum of 2 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged

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2. The national average 2022 Medicare rates and status indicators for the hospital outpatient setting are from the 2022 January 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]. The national average 2022 Medicare rates and payment indicators for the ambulatory surgical center setting are from the 2022 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.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.

Extremity Imaging

Facility Payment

CPT® Code[1]	Description	Place-of-Service	APC[2]	Status Indicator (SI)[2]	2022 National Average Medicare Rate[2]
Radiologic Examination					
73560	Radiologic examination, knee, 1 or 2 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73600	Radiologic examination, ankle, 2 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
73610	Radiologic examination, ankle, complete, minimum of 3 views	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
Bone / Joint Studies					
77071	Manual application of stress performed by physician or other qualified health care professional for joint radiography, including contralateral joint if indicated	Hospital	5521	Q1	$82.61
		ASC	NA	N1	Packaged
77077	Joint survey, single view, 2 or more joints (specify)	Hospital	5522	Q1	$111.19
		ASC	NA	N1	Packaged

Status Indicator Information[3]

Status Indicator (SI)	Explanation
OPPS Status Indicator	
Q1	Payment is packaged if billed on the same claim 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**
ASC Payment Indicator	
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 RVUs

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3. The OPPS Payment Status Indicators for CY 2022 are from the 2022 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum D1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip [cms.gov]. The ASC Payment Indicators for CY 2022 are from the 2022 Ambulatory Surgical Center Payment Final Rule, Addenda DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip [cms.gov].

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