2022
coding & reimbursement guide

BREAST HEALTH SOLUTIONS

HOLOGIC®
The Science of Sure

Breast Imaging: Breast Ultrasound

Global and Physician Professional Payment

CPT® Code[1]	Description	Place-of-Service	RVU[2]	2022 National Average Medicare Rate[3]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Global (Office/Freestanding)	3.10	$107.28
		Professional (Facility/Non-Facility)	1.03	$35.64
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Global (Office/Freestanding)	2.54	$87.90
		Professional (Facility/Non-Facility)	0.96	$33.22
Elastography				
76981	Ultrasound, elastography; parenchyma (eg, organ)	Global (Office/Freestanding)	3.13	$108.32
		Professional (Facility/Non-Facility)	0.85	$29.42
76982	Ultrasound, elastography; first target lesion	Global (Office/Freestanding)	2.82	$97.59
		Professional (Facility/Non-Facility))	0.85	$29.42
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Global (Office/Freestanding)	1.83	$63.33
		Professional (Facility/Non-Facility)	0.72	$24.92

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2. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Relative Value Files, file RVU22A, available from the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.
3. The national average 2022 Medicare rates to physicians shown are based on the 2022 conversion factor of $34.6062 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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Facility Payment

CPT® Code[1]	Description	Place-of-Service	APC[2]	Status Indicator	2022 National Average Medicare Rate[2]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Hospital	5522	Q1[3]	$111.19
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Hospital	5521	Q1[3]	$82.61
Elastography					
76981	Ultrasound, elastography; parenchyma (eg, organ)	Hospital	5522	Q3[4]	$111.19
76982	Ultrasound, elastography; first target lesion	Hospital	5522	Q3[4]	$111.19
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Hospital	NA	N[5]	NA

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2. The national average 2022 Medicare rates 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 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.
3. 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.
4. 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.
5. Status indicator "N" means payment is packaged into payment for other services. Therefore there is no 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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