2026
coding & reimbursement guide

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Breast Imaging: Mammography

Global, Professional and Technical Payment

CPT®[1] / HCPCS[2] Code	Description	Place-of-Service	RVU[3]	2026 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)	3.78	$126.89
		Professional (Facility/Non-Facility)	1.05	$35.25
		Technical (Facility)	2.73	$91.64
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Global (Office/Freestanding)	1.54	$51.69
		Professional (Facility/Non-Facility)	0.83	$27.86
		Technical (Facility)	0.71	$23.83
Diagnostic Breast Tomosynthesis (Unilateral)				
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global (Office/Freestanding)	3.71	$124.54
		Professional (Facility/Non-Facility)	1.13	$37.93
		Technical (Facility)	2.58	$86.60
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Global (Office/Freestanding)	1.21	$40.62
		Professional (Facility/Non-Facility)	0.83	$27.86
		Technical (Facility)	0.38	$12.76
Diagnostic Breast Tomosynthesis (Bilateral)				
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global (Office/Freestanding)	4.70	$157.77
		Professional (Facility/Non-Facility)	1.39	$46.66
		Technical (Facility)	3.31	$111.11
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Global (Office/Freestanding)	1.21	$40.62
		Professional (Facility/Non-Facility)	0.83	$27.86
		Technical (Facility)	0.38	$12.76

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), 2026 Current Procedural Terminology (CPT), Professional Edition. CPT copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the AMA.
2. Centers for Medicare & Medicaid Services (CMS), 2026 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update
3. The 2026 physician relative value units (RVUs) are from the 2026 National Physician Fee Schedule Relative Value File January Release available from the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu26a.
4. Beginning in 2026, there will be two separate conversion factors (CFs): one for items and services furnished by a qualifying alternative payment model (APM) participant (referred to as the qualifying APM conversion factor) and another for other items and services furnished by a nonqualifying APM participant (referred to as the nonqualifying APM conversion factor). The national average 2026 Medicare rates to physicians shown are based on the 2026 CF for qualifying APM participants of $33.5675 and do not reflect payment cuts due to sequestration (the nonqualifying APM conversion factor is $33.4009). Medicare payment for a given procedure in a given locality in 2026 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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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)[4], or (2) 76499 and Q9967 without a code for a mammography procedure.

CPT® Code / HCPCS Code	Description	Place-of-Service	RVU[1]	2026 National Average Medicare Rate[3]
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	1.13	$37.93
		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	$0.149/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)[4], or (2) 76499 and Q9967 without a code for a mammography procedure.

CPT® Code / HCPCS Code	Description	Place-of-Service	APC[2]	Status Indicator[2]	2026 National Average Medicare Rate[2]
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Hospital	5693	S[5]	$217.31
76499	Unlisted diagnostic radiographic procedure	Hospital	5521	Q1[6]	$88.91
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Hospital	NA	N	NA

1. The 2026 physician RVUs are from the 2026 National PFS Relative Value File January Release available from the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu26a.
2. The national average 2026 Medicare hospital outpatient rates and status indicators are from the 2026 Hospital Outpatient Prospective Payment System (OPPS) release, Addenda B, and D1 accessible at https://www.cms.gov/license/ama?file=/files/zip/2026-nfrm-opps-addenda.zip. 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.
3. The national average 2026 Medicare rates to physicians shown are based on the 2026 CF for qualifying APM participants of $33.5675 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2026 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 January 2026 ASP Pricing File, available at https://www.cms.gov/files/zip/january-2026-medicare-part-b-payment-limit-files.zip, and is subject to change in subsequent pricing files.
4. CPT 2026, Professional Edition, advises, "Do not report 96365-96379 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 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.

This information is intended for an audience with knowledge and expertise in health care economic analysis for use in device acquisition, coverage, and/or reimbursement decisions on a population basis and is not intended for use in clinical decision making.

Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which CPT®/HCPCS codes and modifiers to use, as 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 medical professional and/or facility. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide. Any payment rates listed are Medicare averages that may be subject to change without notice.

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