

## Extremity Imaging

### Global and Physician Professional Payment

CPT <sup>1</sup> Code <sup>1</sup>	Description	Place-of-Service	RVU <sup>2</sup>	2024 National Average Medicare Rate <sup>3</sup>
Fluoroscopy				
76000 <sup>i</sup>	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	Global (Office/Freestanding)	1.28	\$41.91
		Professional (Facility/Non-Facility)	0.44	\$14.41
		Technical (Non-Facility)	0.84	\$27.51
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)	3.48	\$113.95
		Professional (Facility/Non-Facility)	0.79	\$25.87
		Technical (Non-Facility)	2.69	\$88.08
Radiologic Examination				
73030	Radiologic examination, shoulder; complete, minimum of 2 views	Global (Office/Freestanding)	1.04	\$34.38
		Professional (Facility/Non-Facility)	0.27	\$8.84
		Technical (Non-Facility)	0.78	\$25.54
73100	Radiologic examination, wrist; 2 views	Global (Office/Freestanding)	1.02	\$33.40
		Professional (Facility/Non-Facility)	0.24	\$7.86
		Technical (Non-Facility)	0.78	\$25.54
73110	Radiologic examination, wrist, complete, minimum of 3 views	Global (Office/Freestanding)	1.24	\$40.60
		Professional (Facility/Non-Facility)	0.25	\$8.19
		Technical (Non-Facility)	0.99	\$32.42
73120	Radiologic examination, hand, 2 views	Global (Office/Freestanding)	0.95	\$31.11
		Professional (Facility/Non-Facility)	0.24	\$7.86
		Technical (Non-Facility)	0.71	\$23.25
73130	Radiologic examination, hand, minimum of 3 views	Global (Office/Freestanding)	1.12	\$36.67
		Professional (Facility/Non-Facility)	0.25	\$8.19
		Technical (Non-Facility)	0.87	\$28.49

#### 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), 2024 Current Procedural Terminology (CPT), Professional Edition. CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

2. The 2024 physician relative value units (RVUs) are from the 2024 Physician Fee Schedule (PFS) Relative Value Files, file RVU23A available from the CMS website at <https://www.cms.gov/files/zip/cy-2024-pfs-final-rule-addenda.zip>.

3. The national average 2024 Medicare rates to physicians shown are based on the 2024 conversion factor of \$32.7442 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2024 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.

## Extremity Imaging

### Global and Physician Professional Payment

CPT* Code	Description	Place-of-Service	RVU¹	2024 National Average Medicare Rate²
Radiologic Examination				
73140	Radiologic examination, finger or fingers, minimum of 2 views	Global (Office/Freestanding)	1.15	\$37.66
		Professional (Facility/Non-Facility)	0.20	\$6.55
		Technical (Non-Facility)	0.95	\$31.11
73560	Radiologic examination, knee, 1 or 2 views	Global (Office/Freestanding)	1.03	\$33.73
		Professional (Facility/Non-Facility)	0.24	\$7.86
		Technical (Non-Facility)	0.79	\$25.87
73600	Radiologic examination, ankle, 2 views	Global (Office/Freestanding)	0.97	\$31.76
		Professional (Facility/Non-Facility)	0.23	\$7.53
		Technical (Non-Facility)	0.74	\$24.23
73610	Radiologic examination, ankle, complete, minimum of 3 views	Global (Office/Freestanding)	1.1	\$36.02
		Professional (Facility/Non-Facility)	0.25	\$8.19
		Technical (Non-Facility)	0.85	\$27.83
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	\$54.03
		Professional (Facility)	1.65	\$54.03
		Technical (Non-Facility)	NA	NA
77077	Joint survey, single view, 2 or more joints (specify)	Global (Office/Freestanding)	1.41	\$46.17
		Professional (Facility/Non-Facility)	0.49	\$16.04
		Technical (Non-Facility)	0.92	\$30.12

1. The 2024 physician relative value units (RVUs) are from the 2024 Physician Fee Schedule (PFS) Relative Value Files, file RVU24A available from the CMS website at <https://www.cms.gov/files/zip/cy-2024-pfs-final-rule-addenda.zip>.

2. The national average 2024 Medicare rates to physicians shown are based on the 2024 conversion factor of \$32.7442 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2024 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.

## Extremity Imaging Facility Payment

CPT® Code	Description	Place-of-Service	APC¹	Status Indicator (SI)¹	2024 National Average Medicare Rate¹
Fluoroscopy					
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	Hospital	5523	S	\$233.71
		ASC	NA	Z3	\$27.18
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	\$86.67
		ASC	NA	N1	Packaged
73100	Radiologic examination, wrist; 2 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged
73110	Radiologic examination, wrist, complete, minimum of 3 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged
73120	Radiologic examination, hand, 2 views	Hospital	5522	Q1	\$104.87
		ASC	NA	N1	Packaged
73130	Radiologic examination, hand, minimum of 3 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged
73140	Radiologic examination, finger or fingers, minimum of 2 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged

1. The national average 2024 Medicare hospital outpatient rates and status indicators are from the 2024 Hospital Outpatient Prospective Payment System (OPPS) release, Addenda B, and D1 accessible at <https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip>. The national average 2024 Medicare ambulatory surgical center rates and payment indicators are from the 2024 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at <https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.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.

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.

## Extremity Imaging Facility Payment

CPT <sup>1</sup> Code	Description	Place-of-Service	APC <sup>1</sup>	Status Indicator (SI) <sup>1</sup>	2024 National Average Medicare Rate <sup>1</sup>
Radiologic Examination					
73560	Radiologic examination, knee, 1 or 2 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged
73600	Radiologic examination, ankle, 2 views	Hospital	5521	Q1	\$86.67
		ASC	NA	N1	Packaged
73610	Radiologic examination, ankle, complete, minimum of 3 views	Hospital	5521	Q1	\$86.67
		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	\$86.67
		ASC	NA	N1	Packaged
77077	Joint survey, single view, 2 or more joints (specify)	Hospital	5522	Q1	\$104.87
		ASC	NA	N1	Packaged

### Status Indicator Information<sup>2</sup>

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

- The national average 2024 Medicare hospital outpatient rates are from the 2024 Hospital Outpatient Prospective Payment System (OPPS) release, Addenda B, and D1 accessible at <https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip>. The national average 2024 Medicare ambulatory surgical center rates and payment indicators are from the 2024 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at <https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.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.
- The OPPS Payment Status Indicators for CY 2024 are from the 2024 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum D1, accessible at <https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip>. The ASC Payment Indicators for CY 2024 are from the 2024 Ambulatory Surgical Center Payment Final Rule, Addenda DD1, accessible at <https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip>.

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.

[hologic.com](https://hologic.com) | [Hologic@thepinnaclehealthgroup.com](mailto:Hologic@thepinnaclehealthgroup.com) | 1.866.369.9290