2026
coding & reimbursement guide

BREAST HEALTH SOLUTIONS

HOLOGIC

Breast Surgery

Physician Professional Payment

CPT®[1] Code/ HCPCS[2] Code	Description	Place-of-Service	RVU[3]	2026 National Average Medicare Rate[4]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Professional (Facility)	18.94	$632.61
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Professional (Facility)	25.97	$867.42
38500	Biopsy or excision of lymph node(s); open, superficial	Professional (Facility)	7.35	$245.50
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Professional (Facility)	12.89	$430.54
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Professional (Facility)	3.68	$122.92
76098	Radiological examination, surgical specimen	Professional (Facility)	0.44	$14.70

Facility Payment

CPT®[1] Code / HCPCS[2] Code	Description	Place-of-Service	APC[5]	Status Indicator[5]	2026 National Average Medicare Rate[5]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Hospital	5091	J1	$4,000.24
		ASC	NA	A2	$1603.18
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Hospital	5092	J1	$6783.99
		ASC	NA	A2	$2,848.20
38500	Biopsy or excision of lymph node(s); open, superficial	Hospital	5091	J1	$4,000.24
		ASC	NA	A2	$1603.18
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Hospital	5091	J1	$4,000.24
		ASC	NA	A2	$1603.18
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
76098	Radiological examination, surgical specimen	Hospital	5524	Q2	$558.25
		ASC	NA	N1	Packaged

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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 Physician Fee Schedule (PFS) Addendum B, Relative Value Units and Related Information available from the CMS website at https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda-updated-11-18-2025.zip.
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 (referred to as the nonqualifying APM conversion factor), equal to the respective conversion factor for the previous year (or, for CY 2026, equal to the single conversion factor for CY 2025) multiplied by the update established for such respective conversion factor for such year. The national average 2026 Medicare rates to physicians shown are based on the 2026 CF for nonqualifying APM participants of $33.4009 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.
5. 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. The national average 2026 Medicare ambulatory surgical center rates and payment indicators are from the 2026 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2026-nfrm-addendum-aa-bb-dd1-dd2-ee-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.

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Modifier Information[1]

Modifier	Description	Explanation
26	Professional component	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number
59	Distinct Procedural Service	Under certain circumstances, it may be necessary to indicate that procedure or service was distinct or independent from other non-E/M services performed on the same day
76	Repeat procedure or service by same physician or other qualified health care professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: this modifier should not be appended to an E/M service
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service
XE*	Separate Encounter	A service that is distinct because it occurred during a separate encounter
XP*	Separate Practitioner	A service that is distinct because it was performed by a different practitioner

* Specific Modifiers for Distinct Procedural Services, CMS Transmittal 1422, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

Status Indicator Information[5]

Status Indicator	OPPS Status Indicator
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
J1	Comprehensive APC paid under OPPS; all covered Part B services on the claim are packaged with the primary “J1” service for the claim, except services with status indicator “F”, “G”, “H”, “L” and “U”
Q2	Q2 is packaged if on the same “claim” rather than date of service.
S	Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply
Payment Indicator	**ASC Payment Indicator**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
J8	Device-intensive procedure; paid at adjusted rate
N1	Packaged service/item; no separate payment made

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2. Centers for Medicare & Medicaid Services (CMS), 2026 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
3. The 2026 physician relative value units (RVUs) are from the 2026 Physician Fee Schedule (PFS) Relative Value Files, file RVU24A available from the CMS website at https://www.cms.gov/files/zip/cy-2025-pfs-final-rule-addenda.zip.
4. The national average 2026 Medicare rates to physicians shown are based on the 2026 conversion factor of $33.5675 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2025 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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hologic.com | Hologic@thepinnaclehealthgroup.com | 1.866.369.9290