

Contrast Enhanced Mammography & Biopsy Coding & Reimbursement FAQ

Hologic Inc., provides this 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.

Contrast Enhanced Mammography (CEM)

1. What CPT^{®1} and HCPCS² Codes are relevant when CEM is performed?

When CEM is performed a regular 2D image is always acquired, therefore providers can report CEM as described below.

CPT ^{®1} /HCPCS Code ²		Description	Place-of-Service	2026 National Average Medicare Rate ^{3,4,5}
Digital Mammography	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global (Office/Freestanding)	\$124.54
			Professional (Facility)	\$37.93
			Technical (Facility)	\$86.60
	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global (Office/Freestanding)	\$157.77
			Professional (Facility)	\$46.66
			Technical (Facility)	\$111.11
Injection	96374*	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	\$37.93
			Professional (Facility)	N/A
			Technical (Facility)	\$217.31
Contrast	Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Global (Office/Freestanding)	\$0.149/ml
			Technical (Facility)	Packaged

2. What billing edits are pertinent for CEM?

CPT 2026, Professional Edition, advises, "Do not report 96365-96479 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.

There are no National Correct Coding Initiative (NCCI) procedure-to-procedure edits pertinent to billing CPT code 96374 with the above CEM codes. Contact your local payer for specific coding and coverage guidelines.

* CPT 2026. Consult your payer for its instructions on how to bill for contrast-enhanced mammography.

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.

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3. Does Medicare pay separately for the injection (CPT code 96374; therapeutic, prophylactic, or diagnostic injection (specify substance or drug; intravenous push, single or initial substance/drug)) of contrast material when performing Contrast Enhanced Mammography?

Hospital Outpatient: Medicare provides separate reimbursement to hospitals (technical payment) for the injection of contrast material under the Outpatient Prospective Payment System. In the hospital outpatient setting, there is no additional reimbursement for the physician for the injection service.

Office/Freestanding: Medicare provides separate reimbursement for the injection of contrast material in the freestanding/office setting.

4. Does Medicare pay separately for the contrast material (HCPCS code Q9967; low osmolar contrast material, 30-399 mg/ml iodine concentration, per ml) used during Contrast Enhanced Mammography exams?

Hospital Outpatient: Medicare does not provide separate payment for Q9967 in the hospital outpatient setting because payment has been packaged with the primary procedure. Facilities should still report Q9967 to ensure that all costs associated with a procedure are captured and used when determining future payment rates.

Office/Freestanding: Medicare pays separately for contrast material, based on reported average sales price, wholesale acquisition cost, or invoice price, when furnished in physicians' offices.

5. If a patient has previously had a diagnostic mammogram, can she have a Contrast Enhanced Mammogram?

Yes. Subject to any applicable payer policy, patients can have a diagnostic mammogram and a contrast enhanced mammogram if the payer determines the medical necessity for follow up imaging. Both procedures may be subject to the patient's deductible and co-insurance.

Diagnostic mammography services do not have a global period, meaning providers do not have to wait a specific amount of time before being able to bill for another procedure.

6. How do imaging centers bill for a screening and diagnostic mammogram performed on the same day?

If a provider performs a screening mammogram and a diagnostic mammogram on the same day, the modifier GG (performance and payment of a screening mammogram and diagnostic mammography on the same patient, same day,) and 59 (distinct procedural service) may be used to report the performance of both studies. Subject to guidance from a payer, providers may bill for both the screening and diagnostic mammogram on the same claim.

7. Is Contrast Enhanced Mammography considered a covered service?

Insurance coverage will vary by plan. In the absence of a plan policy for coverage of CEM, coverage is determined on a claim-by-claim basis. Medicare does not have a coverage policy regarding CEM, so coverage is determined on a claim-by-claim basis.

CEM is not covered as preventative care because it is considered a diagnostic study.

When covered as a diagnostic study, patients may be responsible for their deductible and/or co-insurance depending on their insurance plan.

Contrast Enhanced Biopsy (CEB)

8. What CPT and HCPCS Codes are relevant when CEB is performed?

CEB incorporates the use of stereotactic guidance to help locate a breast abnormality, the specific tissue to be biopsied, and the administration of a contrast agent into the patient's breast tissue to obtain contrast enhanced images. Therefore, providers can report CEB in the following way:

CPT^{®1}/HCPCS Code²		Description	Place-of-Service	2026 National Average Medicare Rate^{3,4,5,6}
Stereotactic biopsy	19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Global (Office/Freestanding)	\$481.02
			Professional (Facility)	\$138.97
			Technical (Facility)	\$1,687.37
			ASC	\$742.04
Injection	96374 ¹	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	\$37.93
			Professional (Facility)	N/A
			Technical (Facility)	\$217.31
Contrast	Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Global (Office/Freestanding)	\$0.149/ml
			Technical (Facility)	Packaged

¹Modifier 59 "distinct procedural service" may need to be appended to 96374 per discussion below.

9. What billing edits are pertinent for CEB?

CPT 2026, Professional Edition, advises, "Do not report 96365-96479 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)." Relatedly, CPT codes 19081 and 96374 are subject to a NCCI procedure-to-procedure edit; however, a modifier is allowed in order to permit billing the two codes together. Because the administration of a contrast agent during a stereotactic biopsy is a choice made by the provider and is not usually part of the procedure, use of both codes with modifier 59 appended to CPT code 96374 to identify the service as a distinct procedural service may be appropriate. Consult your payer for its instructions on how to bill for contrast-enhanced biopsy.

10. Does Medicare pay separately for the injection (CPT code 96374; therapeutic, prophylactic, or diagnostic injection (specify substance or drug; intravenous push, single or initial substance/drug)) of contrast material when performing Contrast Enhanced Biopsy?

Hospital Outpatient: Medicare may provide separate reimbursement to hospitals (technical payment) for the injection of contrast material under the Outpatient Prospective Payment System when the appropriate modifier is appended to the CPT code.

In the hospital outpatient setting, there is no additional reimbursement for the physician for the injection service.

Office/Freestanding: Medicare may provide separate reimbursement for the injection of contrast material in the office/freestanding setting when the appropriate modifier is appended to the CPT code.

11. Does Medicare pay separately for the contrast material (HCPCS code Q9967; low osmolar contrast material, 30-399 mg/ml iodine concentration, per ml) used during Contrast Enhanced Biopsy?

Hospital Outpatient: Medicare does not provide separate payment for Q9967 in the hospital outpatient setting because payment for the contrast material is packaged with the payment for the primary procedure. Facilities should still report Q9967 to ensure that all costs associated with a procedure are captured.

Office/Freestanding: Medicare pays separately for contrast material, based on reported average sales price, wholesale acquisition cost, or invoice price, when furnished in physicians' offices.

CEM & CEB

12. What reimbursement resources does Hologic provide?

We understand how important it is to deliver advanced testing, imaging and treatment solutions that bring greater certainty to clinicians – and make a real difference in the lives of patients looking for answers. That's why we stand behind our innovative solutions, with information to assist our customers as well as providing access to a coding and reimbursement service through an independent third party certified and Health Insurance Portability and Accountability Act (HIPAA) compliant coding company.*

The Pinnacle Health Group provides reimbursement and coding support through a staff of professional certified coders and can address the following:

- Coding Questions
- Insurance Coverage
- Private Payer Contracted Rates (PPR)
- Patient Benefit Verification
- Patient Pre-authorization / Pre-certification
- Claims Appeals and Denials
- HIPAA Compliance Support

Telephone: 866.369.9290

Email: hologic@thepinnaclehealthgroup.com

Available Monday-Friday 8:30am – 6:00pm EST

***Response from Pinnacle Health Group may take 2–3 business days.**

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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 national average 2026 Medicare rates to physicians shown are based on the 2026 conversion factor for qualifying alternative payment model (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 is available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at <http://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 to physicians for Q9967 comes from the January 2026 ASP Pricing File, available at <https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files>, and is subject to subsequent pricing files.

4. 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>.

5. The national average 2026 Medicare Technical (Facility) rates for CPT codes 76499 and 96374 and HCPCS code Q9967 can be found in the 2026 Hospital Outpatient Prospective Payment System Final Rule Addendum B accessible at <https://www.cms.gov/license/ama?file=/files/zip/2026-nfrm-opps-addenda.zip>.

6. The national average 2026 Medicare ambulatory surgical center rates and payment indicators are from the 2026 Ambulatory Surgical Center Payment Final Rule, 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>.

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