2020
coding & reimbursement guide

BREAST HEALTH SOLUTIONS

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Breast Imaging: Mammography

Global, Professional and Technical Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2020 National Average Medicare Rate[3]
Screening Breast Tomosynthesis (Bilateral)				
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Office/Freestanding (Global)	3.86	$139.31
		Facility (Professional)	1.09	$39.34
		Facility (Technical)	2.77	$99.97
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	1.55	$55.94
		Facility (Professional)	0.85	$30.68
		Facility (Technical)	0.70	$25.26
Diagnostic Breast Tomosynthesis (Unilateral)				
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Office/Freestanding (Global)	3.78	$136.42
		Facility (Professional)	1.16	$41.86
		Facility (Technical)	2.62	$94.55
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Office/Freestanding (Global)	1.55	$55.94
		Facility (Professional)	0.85	$30.68
		Facility (Technical)	0.70	$25.26
Diagnostic Breast Tomosynthesis (Bilateral)				
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Office/Freestanding (Global)	4.76	$171.79
		Facility (Professional)	1.42	$51.25
		Facility (Technical)	3.34	$120.54
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Office/Freestanding (Global)	1.55	$55.94
		Facility (Professional)	0.85	$30.68
		Facility (Technical)	0.70	$25.26

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2. The 2020 physician relative value units (RVUs) are from the2020 Physician Fee Schedule (PFS) Final Rule, Addendum B accessible available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-Addenda.zip.
3. The national average 2020 Medicare rates to physicians shown are based on the 2020 conversion factor of $36.0896 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2020 should be 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.

Breast Imaging: Contrast-Enhanced Mammography

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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)[5], or (2) 76499 and Q9967 without a code for a mammography procedure

CPT® Code[1]	Description	Site of Service Component	RVU[2] or APC[3]	2020 National Average Medicare Rate[4]
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Office/Freestanding (Global)	1.11	$40.06
		Facility (Professional)	NA	NA
		Facility (Technical)	APC 5693 with status indicator S[6]	$183.72
76499	Unlisted diagnostic radiographic procedure	Office/Freestanding (Global)	NA	Determined by contractors
		Facility (Professional)	NA	Determined by contractors
		Facility (Technical)	APC 5521 with status indicator Q1[7]	$79.80
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Office/Freestanding (Global)	NA	$0.115/m
		Facility (Professional)	NA	NA
		Facility (Technical)	NA	

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2. The 2020 physician relative value units (RVUs) are from the2020 Physician Fee Schedule (PFS) Final Rule, Addendum B accessible available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-Addenda.zip.
3. The national average 2020 Medicare rates and status indicators for the hospital outpatient setting are from the 2020 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addenda B and D1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. The national average 2020 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2020 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. 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.
4. The national average 2020 Medicare rates to physicians shown are based on the 2020 conversion factor of $36.0896 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2020 should be 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
5. CPT 2020, 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. Consult your payer for its instructions on how to bill for contrast-enhanced mammography.
6. Status indicator "S" means procedure is significant and not subject to multiple procedure discount.
7. 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.

Breast Imaging: Breast Ultrasound

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CPT® Code[1]	Description	Site of Service Component	RVU[2] or APC[3]	2020 National Average Medicare Rate[4]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Office/Freestanding (Global)	3.02	$108.99
		Facility (Professional)	1.03	$37.17
		Facility (Technical)	APC 5522 with status indicator Q1[5]	$112.07
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Office/Freestanding (Global)	2.47	$89.14
		Facility (Professional)	0.96	$34.65
		Facility (Technical)	APC 5521 with status indicator Q1[5]	$79.80
Elastography				
76981	Ultrasound, elastography; parenchyma (eg, organ)	Office/Freestanding (Global)	3.04	$109.71
		Facility (Professional)	0.84	$30.32
		Hospital Outpatient	APC 5522 with status indicator Q3	$112.07
76982	Ultrasound, elastography; first target lesion	Office/Freestanding (Global)	2.71	$97.80
		Facility (Professional)	0.84	$30.32
		Hospital Outpatient	APC 5522 with status indicator Q3	$112.07
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	1.67	$60.27
		Facility (Professional)	0.71	$25.62
		Hospital Outpatient	APC NA with status indicator N	$0.00

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2. The 2020 physician relative value units (RVUs) are from the2020 Physician Fee Schedule (PFS) Final Rule, Addendum B accessible available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2020-PFS-FR-Addenda.zip.
3. The national average 2020 Medicare rates and status indicators for the hospital outpatient setting are from the 2020 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addenda B and D1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. The national average 2020 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2020 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. 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.
4. The national average 2020 Medicare rates to physicians shown are based on the 2020 conversion factor of $36.0896 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2020 should be 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
5. 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.

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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