

Breast Surgery

Physician Professional Payment

CPT® Code/ HCPCS Code ¹	Description	Site of Service Component	RVU ²	2020 National Average Medicare Rate ³
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Facility (Professional)	19.06	\$687.87
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Facility (Professional)	26.20	\$945.55
19316	Mastopexy	Facility (Professional)	22.37	\$807.32
19318	Reduction mammoplasty	Facility (Professional)	31.72	\$1,144.76
38500	Biopsy or excision of lymph node(s); open, superficial	Facility (Professional)	7.38	\$266.34
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Facility (Professional)	12.70	\$458.34
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)	Facility (Professional)	4.03	\$145.44
76098	Radiological examination, surgical specimen	Facility (Professional)	0.45	\$16.24
19499	Unlisted Procedure, breast	Facility (Professional)	N/A	Determined by contractors

Facility Payment

CPT® Code/ HCPCS Code ¹	Description	Site of Service Component	APC ⁴	Status Indicator ⁴	2020 National Average Medicare Rate ⁴
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Hospital	5091	J1	\$3,029.21
		ASC	NA	A2	\$1,118.44
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Hospital	5092	J1	\$5,236.71
		ASC	NA	A2	\$2,193.27
19316	Mastopexy	Hospital	5092	J1	\$5,236.71
		ASC	NA	A2	\$2,193.27
19318	Reduction mammoplasty	Hospital	5092	J1	\$5,236.71
		ASC	NA	A2	\$2,193.27
38500	Biopsy or excision of lymph node(s); open, superficial	Hospital	5091	J1	\$3,029.21
		ASC	NA	A2	\$1,118.44
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Hospital	5091	J1	\$3,029.21
		ASC	NA	A2	\$1,118.44
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	\$481.53
		ASC	NA	N1	Packaged
19499	Unlisted procedure, Breast	Hospital	5091	J1	\$3,029.21
		ASC	NA	NA	NA
C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple	Hospital	5613	S	\$1,245.20
		ASC	NA	G2	\$629.26

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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Modifier Information¹

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 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 Information⁴

Status Indicator	HOPPS Status Indicator
T	Paid separately under OPSS but multiple procedure reduction applies
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
J1	Comprehensive APC paid under OPSS; 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"
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
Q2	Q2 Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T"
S	Significant procedure paid as separate APC payment under OPSS. Multiple procedure reduction does not apply
U	Brachytherapy sources paid as separate APC payment under OPSS

Status Indicator	ASC Payment Indicator
A2	Surgical procedure on ASC list in CY 2007; payment based on OPSS relative payment weight
G2	Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPSS relative payment weight
J8	Device-intensive procedure; paid at adjusted rate
N1	Packaged service/item; no separate payment made

- American Medical Association (AMA), 2020 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2019 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2020 Healthcare Common Procedure Coding System (HCPCS) codes, available at <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>
- The 2020 physician relative value units (RVUs) are from the 2020 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>.
- 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.
- The national average 2020 Medicare rates and status indicators for the hospital outpatient setting are from the 2020 Hospital Outpatient Prospective Payment System (OPSS) 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&LSort=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.

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hologic.com | Hologic@thepinnaclehealthgroup.com | 1.866.369.9290

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