

Breast Imaging

Global, Professional and Technical Payment

CPT® Code ¹	Description	Site of Service Component	RVU ²	2019 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)	3.84	\$138.39
		Facility (Professional)	1.08	\$38.92
		Facility (Technical)	2.76	\$99.47
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	1.55	\$55.86
		Facility (Professional)	0.85	\$30.63
		Facility (Technical)	0.70	\$25.23
Diagnostic Breast Tomosynthesis (Unilateral)				
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Office/Freestanding (Global)	3.77	\$135.87
		Facility (Professional)	1.16	\$41.81
		Facility (Technical)	2.61	\$94.06
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Office/Freestanding (Global)	1.55	\$55.86
		Facility (Professional)	0.85	\$30.63
		Facility (Technical)	0.70	\$25.23
Diagnostic Breast Tomosynthesis (Bilateral)				
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Office/Freestanding (Global)	4.77	\$171.91
		Facility (Professional)	1.43	\$51.54
		Facility (Technical)	3.34	\$120.37
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to 77065 and 77066)	Office/Freestanding (Global)	1.55	\$55.86
		Facility (Professional)	0.85	\$30.63
		Facility (Technical)	0.70	\$25.23

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- The 2019 physician relative value units (RVUs) are from the January 2019 RVU file (RVU19A) available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending>.
- The national average 2019 Medicare rates to physicians shown are based on the 2019 conversion factor of \$36.0391 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2019 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.

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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CPT® Code ¹	Description	Site of Service Component	RVU or APC ²	2019 National Average Medicare Rate ³
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) ⁴ , or (2) 76499 and Q9967 without a code for a mammography procedure				
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Office/Freestanding (Global)	1.10	\$39.64
		Facility (Professional)	NA	NA
		Facility (Technical) (Hospital Outpatient)	APC 5693 with status indicator S ⁵	\$187.18
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 ⁶	\$62.30
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Office/Freestanding (Global)	Packaged	NA
		Facility (Professional)	Packaged	NA
		Facility (Technical)	Packaged	NA
Breast Ultrasound Effective January 1, 2015, two new codes were issued for billing Breast Ultrasound, replacing CPT 76645, which has been deleted. CPT 76641 represents a complete ultrasound examination consisting of all four quadrants of the breast and the retroareolar region, including examination of the axilla if performed. CPT 76642 represents a focused ultrasound examination of one or more, but not all four quadrants, and includes examination of the axilla if performed. CPT 76641 and 76642 are unilateral ultrasound examinations. If breast ultrasound is performed bilaterally with either code, it should be billed using a bilateral payment indicator, and will be paid at 150% of the unilateral payment				
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Office/Freestanding (Global)	3.02	\$108.84
		Facility (Professional)	1.04	\$37.48
		Facility (Technical) (Hospital Outpatient)	APC 5522 with status indicator Q1 ⁶	\$112.51
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Office/Freestanding (Global)	2.47	\$89.02
		Hospital	0.97	\$34.96
		Facility (Technical) (Hospital Outpatient)	APC 5521 with status indicator Q1 ⁶	\$62.30

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- CPT 2019, 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.
- Status indicator "S" means procedure is significant and not subject to multiple procedure discount.
- 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.

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