Breast Imaging

Coding and Payment Guide

2018

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU[2]	2018 National Medicare Rate[2]
Mammography				
• HCPCS codes G0202, G0204 and G0206 were deleted for 2018 and replaced with CPT codes 77065-77067 to report diagnostic or screening mammography services. Use of computer-aided detection (CAD) is bundled into CPT codes 77065-77067, when performed. • Medicare pays for mammography services (including tomosynthesis) delivered in either office/freestanding centers or hospital outpatient departments using the physician fee schedule (PFS) rates. There are no separate rates published under the hospital outpatient prospective payment system (OPPS). *Note: For film x-rays, Medicare requires that the FX modifier be appended to the CPT/HCPCS code. This results in a 20 percent payment reduction to the technical component (or technical component of the global service) for film x-rays. Use of mammography systems utilizing computed radiography/ cassette-based imaging must be appended with the FY modifier and will be result in a 7 percent payment reduction to the technical component (or technical component of the global service). Check with your payer for any coding requirements and payment impacts for using film or computed radiography x-ray.*				
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Global Payment	3.88	$139.68
		Professional Component (26)	1.06	$38.16
		Technical Component (TC)	2.82	$101.52
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global Payment	4.80	$172.80
		Professional Component (26)	1.39	$50.04
		Technical Component (TC)	3.41	$122.76
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global Payment	3.79	$136.44
		Professional Component (26)	1.12	$40.32
		Technical Component (TC)	2.67	$96.12
Tomosynthesis				
Breast tomosynthesis codes 77063 and G0279 are billed in conjunction with the appropriate screening or diagnostic mammography code (77065-77067). CPT codes 77061-77062 for diagnostic digital breast tomosynthesis are not utilized by Medicare. Check with your payer to confirm the code(s) accepted for tomosynthesis services.				
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Global Payment	1.56	$56.16
		Professional Component (26)	0.85	$30.60
		Technical Component (TC)	0.71	$25.56
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)	Global Payment	1.56	$56.16
		Professional Component (26)	0.85	$30.60
		Technical Component (TC)	0.71	$25.56

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Breast Ultrasound				

- 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 modifier (i.e., 50, LT, RT), and will be paid at 150% of the unilateral payment.
- Medicare pays for global, technical and professional components of breast ultrasound services delivered in the office/freestanding facility setting under the physician fee schedule (PFS) and technical services delivered in a hospital outpatient department under the hospital outpatient prospective payment system (OPPS). Check with your payer to confirm the code(s) accepted and payment policies for breast ultrasound services.

76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Global Payment (office/freestanding only)	3.06	$110.16
		Professional Component (26)	1.04	$37.44
		Technical Component (TC) (office/freestanding only)	2.02	$72.72
		Hospital payment (outpatient)	APC 5522	$118.74
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Global Payment (office/freestanding only)	2.51	$90.36
		Professional Component (26)	0.97	$34.92
		Technical Component (TC) (office/freestanding only)	1.54	$55.44
		Hospital payment (outpatient)	APC 5521	$62.11

[1]American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT® is a registered trademark of the American Medical Association. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/ HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

[2]The 2018 physician relative value units (RVUs) are from the 2018 Medicare Physician Fee Schedule (PFS) Final Rule, Addendum B. The payment rates are calculated using the 2018 PFS conversion factor of $35.9996 and do not reflect payment cuts due to sequestration or other Medicare policies. Medicare physician payment for a given procedure in a given locality in 2018 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 or hospital 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. Hospital outpatient rates and ambulatory payment classifications (APCs) are from the 2018 Medicare Hospital Outpatient Prospective Payment System (OPPS), Addendum B. PFS Retreived from: Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html; OPPS retreived from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html.

[3]CPT codes 76641 and 76642 have an OPPS status indicator of "Q1," meaning that payment is packaged and not paid separately if billed on the same date of service as a CPT/HCPCS code assigned status indicator "S", "T", or "V"; otherwise payment is made through a separate APC payment.

Siemens 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. Siemens cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide.

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