Breast Imaging

2017 Coding and Payment Guide

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Mammography

In 2017, there are significant changes to mammography codes.
· CPT codes 77055-77065 were deleted for 2017 and replaced with new CPT codes 77065-77067.
· CPT codes 77051-77052 for computer-aided detection (CAD) were also deleted and bundled into CPT codes 77065-77067, if performed.
· For 2017, Medicare utilizes HCPCS codes G0202, G0204, and G0206 to describe mammography services, whether using film or digital images.

Other payers may use either the HCPCS G-codes or the new CPT codes. Check with your payer to confirm the code(s) accepted for mammography services.

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% payment reduction to the technical component (or technical component of the global service) for film X-rays. Check with your payer for any coding requirements and payment impacts for using film X-ray.*

CPT©/ HCPCS Code[1]	Description	Service Component	Total RVU[2]	2017 National Medicare Rate[2]
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Global Payment	3.85	$138.17
		Professional Component (26)	1.05	$37.68
		Technical Component (TC)	2.80	$100.49
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Not applicable for Medicare. Check with your payer.		
G0204	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global Payment	4.77	$171.19
		Professional Component (26)	1.38	$49.53
		Technical Component (TC)	3.39	$121.66
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Not applicable for Medicare. Check with your payer.		
G0206	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global Payment	3.76	$134.94
		Professional Component (26)	1.11	$39.84
		Technical Component (TC)	2.65	$95.11
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Not applicable for Medicare. Check with your payer.		

Tomosynthesis

Breast tomosynthesis codes 77063 and G0279 are billed in conjunction with the appropriate screening or diagnostic mammography code (77065-77067 or G0202, G0204, G0206). 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.

CPT©/ HCPCS Code[1]	Description	Service Component	Total RVU[2]	2017 National Medicare Rate[2]
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Global Payment	1.57	$56.35
		Professional Component (26)	0.86	$30.86
		Technical Component (TC)	0.71	$25.48
G0279	Diagnostic digital breast, tomosynthesis, unilateral or bilateral (List separately in addition to G0204 and G0206)	Global Payment	1.57	$56.35
		Professional Component (26)	0.86	$30.86
		Technical Component (TC)	0.71	$25.48
77061	Digital breast tomosynthesis; unilateral	Not applicable for Medicare. Check with your payer.		
77062	Digital breast tomosynthesis; bilateral	Not applicable for Medicare. Check with your payer.		

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.

CPT©/ HCPCS Code[1]	Description	Service Component	Total RVU/ APC[2,3]	2017 National Medicare Rate[2,3]
76641	Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; complete	Global Payment (office/ freestanding only)	3.05	$109.46
		Professional Component (26)	1.04	$37.32
		Technical Component (TC) (office/freestanding only)	2.01	$72.14
		Hospital payment (outpatient)	APC 5522	$112.73
76642	Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; limited	Global Payment (office/ freestanding only)	2.51	$90.08
		Professional Component (26)	0.97	$34.81
		Technical Component (TC) (office/freestanding only)	1.54	$55.27
		Hospital payment (outpatient)	APC 5521	$59.86

1. American Medical Association (AMA), 2017 Current Procedural Terminology (CPT), Professional Edition. CPT® is a registered trademark of the American Medical Association. CPT codes and descriptions only are copyright 2016 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), 2016 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/ HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

2. The 2017 physician relative value units (RVUs) are from the 2017 Medicare Physician Fee Schedule (PFS) Final Rule, Addendum B. The payment rates are calculated using the 2017 PFS conversion factor of $35.8887 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 2017 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 2017 Medicare Hospital Outpatient Prospective Payment System (OPPS), Addendum B. PFS Retreived from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html.; OPPS retreived from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.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 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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