Breast imaging

2020 Coding and Payment Guide

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Mammography

CPT codes 77065-77067 describe diagnostic or screening mammography services. Use of computer-aided detection (CAD) is bundled into CPT codes 77065-77067.

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.

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU[2]	2020 National Medicare Rate[2]
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Global Payment	3.86	$139.31
		Professional Component (26)	1.09	$39.34
		Technical Component (TC)	2.77	$99.97
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global Payment	4.76	$171.79
		Professional Component (26)	1.42	$51.25
		Technical Component (TC)	3.34	$120.54
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global Payment	3.78	$136.42
		Professional Component (26)	1.16	$41.86
		Technical Component (TC)	2.62	$94.55

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.

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).

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU[2]	2020 National Medicare Rate[2]
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Global Payment	1.55	$55.94
		Professional Component (26)	0.85	$30.68
		Technical Component (TC)	0.70	$25.26
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)	Global Payment	1.55	$55.94
		Professional Component (26)	0.85	$30.68
		Technical Component (TC)	0.70	$25.26
77061	Digital breast tomosynthesis; unilateral	Not applicable for Medicare. Check with your payer		
77062	Digital breast tomosynthesis; bilateral			

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]	2020 National Medicare Rate[2]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Global Payment (office/ freestanding only)	3.02	$108.99
		Professional Component (26)	1.03	$37.17
		Technical Component (TC) (office/freestanding only)	1.99	$71.82
		Hospital payment (outpatient)	APC 5522	$112.08
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Global Payment (office/ freestanding only)	2.47	$89.14
		Professional Component (26)	0.96	$34.65
		Technical Component (TC) (office/freestanding only)	1.51	$54.50
		Hospital payment (outpatient)	APC 5521	$79.81
76982	Ultrasound, elastography; first target lesion	Global Payment (office/ freestanding only)	2.71	$97.80
		Professional Component (26)	0.84	$30.32
		Technical Component (TC) (office/freestanding only)	1.87	$67.49
		Hospital payment (outpatient)	APC 5522	$112.08
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Global Payment (office/ freestanding only)	1.67	$60.27
		Professional Component (26)	0.71	$25.62
		Technical Component (TC) (office/freestanding only)	0.96	$34.65
		Hospital payment (outpatient)	Payment packaged by Medicare	

Breast MRI

CPT codes 77046-77049 are new for 2019 and replace deleted CPT codes 77058, 77059 and 0159T. These codes describe breast magnetic resonance imaging (MRI) services and are divided based on the use of contrast and unilateral vs. bilateral examination.

CPT codes 77048 and 77049 describing breast MRI without followed by with contrast include computer-aided detection (CAD), when performed. For hospital outpatient department payment, without/wqith contrast breast MRI services are reported on the claim with HCPCS codes C8905 and C8908, respectively. Hospital outpatient department payment for CAD under HCPCS code C8937 is packaged into the base code for the procedure, when performed.

Medicare pays for global, technical and professional components of breast MRI 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 MRI services.

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU/ APC[2,3]	2020 National Medicare Rate[2]
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Global Payment (office/ freestanding only)	6.90	$249.02
		Professional Component (26)	2.06	$74.34
		Technical Component (TC) (office/freestanding only)	4.84	$174.67
		Hospital payment (outpatient)	APC 5523	$233.04
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Global Payment (office/ freestanding only)	7.08	$255.51
		Professional Component (26)	2.27	$81.92
		Technical Component (TC) (office/freestanding only)	4.81	$173.59
		Hospital payment (outpatient)	APC 5523	$233.04
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Global Payment (office/ freestanding only)	10.93	$394.46
		Professional Component (26)	2.97	$107.19
		Technical Component (TC) (office/freestanding only)	7.96	$287.27
		Hospital payment (outpatient)	For Medicare, see HCPCS code C8905	
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Global Payment (office/ freestanding only)	11.19	$403.84
		Professional Component (26)	3.26	$117.65
		Technical Component (TC) (office/freestanding only)	7.93	$286.19
		Hospital payment (outpatient)	For Medicare, see HCPCS code C8908	
C8903	Magnetic resonance imaging with contrast, breast; unilateral	Hospital payment (outpatient)	APC 5571	$182.22
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral	Hospital payment (outpatient)	APC 5572	$381.85
C8906	Magnetic resonance imaging with contrast, breast; bilateral	Hospital payment (outpatient)	APC 5572	$381.85
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral	Hospital payment (outpatient)	APC 5572	$381.85
C8937	Computer-aided detection, including computer algorithm analysis of breast mri image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation (list separately in addition to code for primary procedure)	Hospital payment (outpatient)	Payment packaged by Medicare	
76391	Magnetic resonance (e.g., vibration) elastography	Global Payment (office/ freestanding only)	6.54	$236.03
		Professional Component (26)	1.58	$57.02
		Technical Component (TC) (office/freestanding only)	4.96	$179.00
		Hospital payment (outpatient)	APC 5523	$233.04

Percutaneous Breast Biopsy

Percutaneous breast biopsy codes are separated by imaging guidance modality (stereotactic, ultrasound, MRI) and first vs. additional lesions biopsied during the same session. The codes are reported once per lesion, regardless of the number of samples taken from each lesion.

These codes bundle all biopsy, localization device placement and imaging guidance services.

These codes are unilateral. If bilateral procedures are performed, append the 50 modifier or follow your local payer's guidelines.

There are no codes for breast biopsy with mammographic guidance. Use appropriate unlisted code for this procedure.

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU/ APC[2,3]	2020 National Medicare Rate[2]
19081	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Physician facility (office/ freestanding)	4.82	$173.95
		Physician non-facility (i.e., hospital, ASC)	17.34	$625.79
		Hospital payment (outpatient)	APC 5072	$1,372.60
19082	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	2.42	$87.34
		Physician non-facility (i.e., hospital, ASC)	13.98	$504.53
		Hospital payment (outpatient)	N/A	
19083	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	Physician facility (office/ freestanding)	4.56	$164.57
		Physician non-facility (i.e., hospital, ASC)	17.16	$619.30
		Hospital payment (outpatient)	APC 5072	$1,372.60
19084	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	2.25	$81.20
		Physician non-facility (i.e., hospital, ASC)	13.60	$490.82
		Hospital payment (outpatient)	N/A	
19085	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	Physician facility (office/ freestanding)	5.28	$190.55
		Physician non-facility (i.e., hospital, ASC)	26.18	$944.83
		Hospital payment (outpatient)	APC 5072	$1,372.60
19086	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	2.63	$94.92
		Physician non-facility (i.e., hospital, ASC)	20.81	$751.02
		Hospital payment (outpatient)	N/A	

Percutaneous Localization Device Placement (Without Biopsy)

Percutaneous localization device placement codes are separated by imaging guidance modality (mammographic, stereotactic, ultrasound, MRI) and first vs. additional lesions during the same session. The codes are reported once per lesion, regardless of the number of samples taken from each lesion.

These codes bundle all localization device placement and imaging guidance services.

These codes are unilateral. If bilateral procedures are performed, append the 50 modifier or follow your local payer's guidelines.

CPT©/HCPCS Code[1]	Description	Service Component	Total RVU/ APC[2,3]	2020 National Medicare Rate[2]
19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	Physician facility (office/ freestanding)	2.90	$104.66
		Physician non-facility (i.e., hospital, ASC)	6.97	$251.54
		Hospital payment (outpatient)	APC 5071	$610.01
19282	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	1.46	$52.69
		Physician non-facility (i.e., hospital, ASC)	4.92	$177.56
		Hospital payment (outpatient)	N/A	
19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	Physician facility (office/ freestanding)	2.93	$105.74
		Physician non-facility (i.e., hospital, ASC)	7.74	$279.33
		Hospital payment (outpatient)	APC 5071	$610.01
19284	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	1.49	$53.77
		Physician non-facility (i.e., hospital, ASC)	5.90	$212.93
		Hospital payment (outpatient)	N/A	
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	Physician facility (office/ freestanding)	2.49	$89.86
		Physician non-facility (i.e., hospital, ASC)	12.98	$468.44
		Hospital payment (outpatient)	APC 5071	$610.01
19286	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	1.26	$45.47
		Physician non-facility (i.e., hospital, ASC)	11.08	$399.87
		Hospital payment (outpatient)	N/A	
19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	Physician facility (office/ freestanding)	3.72	$134.25
		Physician non-facility (i.e., hospital, ASC)	22.10	$797.58
		Hospital payment (outpatient)	APC 5071	$610.01
19288	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	Physician facility (office/ freestanding)	1.87	$67.49
		Physician non-facility (i.e., hospital, ASC)	17.58	$634.46
		Hospital payment (outpatient)	N/A	

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[2]The 2020 physician relative value units (RVUs) are from the 2020 Medicare Physician Fee Schedule (PFS) Final Rule, Addendum B. The payment rates are calculated using the 2020 PFS conversion factor of $36.0896 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 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 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 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS), Addendum B. PFS retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F; OPPS retreived from: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1717-cn.

[3]CPT codes 76641, 76642, 19281, 19283, 19285 and 19287 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", or with another service assigned to a composite APC. Otherwise, payment is made through a separate APC payment. CPT codes 76391, 76981, 76982, 77046 and 77047, and HCPCS codes C8903, C8905, C8906 and C8908, have an OPPS status indicator of "Q3," meaning that payment is packaged and not paid separately when billed with another service assigned to a composite APC. Otherwise, payment is made through a separate APC payment. CPT codes 19081, 19083 and 19085 have an OPPS statusi indicator of "J1," meaning that all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.

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