2018 coding & reimbursement guide

SKELETAL HEALTH SOLUTIONS

HOLOGIC® The Science of Sure

Bone Densitometry

Global and Physician Professional Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Office/Freestanding (Global)	1.19	$42.84
		Facility (Professional)	0.29	$10.44
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Office/Freestanding (Global)	0.80	$28.80
		Facility (Professional)	0.31	$11.16
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	Office/Freestanding (Global)	1.61	$57.96
		Facility (Professional)	0.43	$15.48
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	Office/Freestanding (Global)	1.03	$37.08
		Facility (Professional)	0.25	$9.00
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Office/Freestanding (Global)	3.26	$117.36
		Facility (Professional)	0.35	$12.60
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Office/Freestanding (Global)	0.21	$7.56
		Facility (Professional)	0.08	$2.88
73551*	Radiologic examination, femur, 1 view	Office/Freestanding (Global)	0.79	$28.44
		Facility (Professional)	0.24	$8.64

* CPT 73551 replaced 73550.

Notes: Global and technical payments reflect the Technical Component (TC) cap required by law. This TC cap only affected the payment rates for CPT code 77078. The Medicare Physician Fee Schedule (MPFS) TC rates for the other CPT® codes were lower than the Hospital Outpatient Prospective Payment System (HOPPS) TC rates, and therefore were not affected. For those Global payment rates with a TC component affected by the TC cap; the Global rate reflects the reduced TC component (i.e., Global = Professional (26) + Technical (TC)).

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 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), 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 latest 2018 RVU file 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.
3. The national average 2018 Medicare rates to physicians shown are based on the 2018 conversion factor of $35.9996 and do not reflect payment cuts due to sequestration. Medicare 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 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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Facility Payment

CPT® Code[1]	Description	APC[2]	Status Indicator (SI)[2]	2018 National Average Medicare Rate[2]
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	5522	S	$118.74
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	5521	S	$62.11
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	5522	Q1	$118.74
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	5521	Q1	$62.11
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	5521	S	$62.11
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	5522	S	$118.74
73551*	Radiologic examination, femur, 1 view	5521	Q1	$62.11

* CPT 73551 replaced 73550.

Notes: Global and technical payments reflect the Technical Component (TC) cap required by law. This TC cap only affected the payment rates for CPT code 77078. The Medicare Physician Fee Schedule (MPFS) TC rates for the other CPT® codes were lower than the Hospital Outpatient Prospective Payment System (HOPPS) TC rates, and therefore were not affected. For those Global payment rates with a TC component affected by the TC cap; the Global rate reflects the reduced TC component (i.e., Global = Professional (26) + Technical (TC)).

Status Indicator Information[2]

Status Indicator (SI)	Explanation
S	Significant procedure not subject to multiple procedure discount
Q1	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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2. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. 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.

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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