2025 coding & reimbursement guide

BREAST HEALTH SOLUTIONS

HOLOGIC

Radiation Treatment **Global and Physician Professional Payment**

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT®[1] / HCPCS[2] Code	Description	Place-of-Service	RVU[3]	2025 National Average Medicare Rate[4]
G6001	Ultrasonic guidance for placement of radiation therapy fields	Global (Freestanding)	5.31	$171.76
		Professional (Facility/Non-Facility)	0.95	$30.73
76965	Ultrasonic guidance for interstitial radioelement application	Global (Freestanding)	2.86	$92.51
		Professional (Facility/Non-Facility)	2.02	$65.34
77014	Computed tomography guidance for placement of radiation therapy fields	Global (Freestanding)	3.58	$115.80
		Professional (Facility/Non-Facility)	1.36	$43.99
77263	Therapeutic radiology treatment planning; complex	Global (Freestanding)	5.10	$164.97
		Professional (Facility/Non-Facility)	NA	NA
77290	Therapeutic radiology simulation-aided field setting; complex	Global (Freestanding)	13.22	$427.62
		Professional (Facility/Non-Facility)	2.48	$80.22
77295*	3-dimensional radiotherapy plan, including dose-volume histograms	Global (Freestanding)	14.59	$471.94
		Professional (Facility/Non-Facility)	6.81	$220.28
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Global (Freestanding)	7.44	$240.66
		Professional (Facility/Non-Facility)	2.22	$71.81
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	Global (Freestanding)	2.74	$88.63
		Professional (Facility/Non-Facility)	NA	NA
77370	Special medical radiation physics consultation	Global (Freestanding)	4.50	$145.56
		Professional (Facility/Non-Facility)	NA	NA
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Global (Freestanding)	4.40	$142.32
		Professional (Facility/Non-Facility)	3.23	$104.48

* Medicare's National Correct Coding Initiative (NCCI) includes edits that will not permit payment for 77290 if reported by the same physician for the same patient on the same date of service when 77295 is reported. NCCI edits only permit the codes 77295 and 77014 to be paid when reported by the same physician for the same patient on the same date if an NCCI-associated modifier is appropriately reported on the claim as well.

Treatment Delivery

CPT® Code[1]	Description	Place-of-Service	RVU[3]	2025 National Average Medicare Rate[4]
77280	Therapeutic radiology simulation-aided field setting; simple	Global (Freestanding)	8.04	$260.07
		Professional (Facility/Non-Facility)	1.13	$36.55
77770[ˈ]	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	Global (Freestanding)	10.49	$339.31
		Professional (Facility/Non-Facility)	3.10	$100.27
77771[ˈ]	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	Global (Freestanding)	18.37	$594.21
		Professional (Facility/Non-Facility)	6.05	$195.70
77799	Unlisted procedure, clinical brachytherapy	Global (Freestanding)	NA	Determined by contractors
		Professional (Facility/Non-Facility)		

[ˈ] Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there is a definite break in therapy sessions.[5] When billing more than one treatment session on the same date of service, the second treatment delivery code may be reported on a separate line and a -59 modifier may be used. Policies regarding the use of modifiers vary by payer; please check with your local payers for specific guidelines.

[ˡ] The radiation source is included within the high dose rate CPT codes

1. American Medical Association (AMA), 2025 Current Procedural Terminology (CPT), Professional Edition. CPT copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
2. Centers for Medicare & Medicaid Services (CMS), 2025 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update
3. The 2025 physician relative value units (RVUs) are from the 2025 Physician Fee Schedule (PFS) Addendum B, Relative Value Units and Related Information available from the CMS website at https://www.cms.gov/files/zip/cy-2025-pfs-final-rule-addenda.zip.
4. The national average 2025 Medicare rates to physicians shown are based on the 2025 conversion factor of $32.3465 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2025 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://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.
5. Section 70.1 of Chapter 13 of the Medicare Claims Processing Manual; available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

Radiation Treatment
Facility Payment

Ultrasonic Guidance, Physics, Dosimetry Planning and Management

CPT® Code	Description	Place-of-Service	APC[1]	Status Indicator[1]	2025 National Average Medicare Rate[1]
76965	Ultrasonic guidance for interstitial radioelement application	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
77014	Computed tomography guidance for placement of radiation therapy fields	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
77290	Therapeutic radiology simulation-aided field setting; complex	Hospital	5612	S	$366.07
		ASC	NA	Z2	$196.49
77295*	3-dimensional radiotherapy plan, including dose-volume histograms	Hospital	5613	S	$1,368.26
		ASC	NA	Z3	$249.39
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Hospital	5612	S	$366.07
		ASC	NA	Z3	$167.55
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	Hospital	5611	S	$132.77
		ASC	NA	Z2	$71.13
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Hospital	5623	S	$578.47
		ASC	NA	Z3	$37.20

* Medicare's National Correct Coding Initiative includes edits that will not permit payment for 77014 or 77290 if either of these codes are reported by the same physician for the same patient on the same date of service when 77295 is reported.

Treatment Delivery

CPT® Code/ HCPCS Code	Description	Place-of-Service	APC[1]	Status Indicator[1]	2025 National Average Medicare Rate[1]
77280	Therapeutic radiology simulation-aided field setting; simple	Hospital	5611	S	$132.77
		ASC	NA	Z2	$71.13
77770†	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	Hospital	5624	S	$693.81
		ASC	NA	Z3	$237.42
77771†	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	Hospital	5624	S	$693.81
		ASC	NA	Z2	$376.27
77799	Unlisted procedure, clinical brachytherapy	Hospital	5621	S	$109.50
		ASC	NA	Z2	$58.80
C1717†	Brachytherapy source, non-stranded high dose rate iridium-192, per source	Hospital	2646	U	$342.39
		ASC	NA	H2	$457.36

† Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there is a definite break in therapy sessions.[2] When billing more than one treatment session on the same date of service, the second treatment delivery code may be reported on a separate line and a -59 modifier may be used. Policies regarding the use of modifiers vary by payer; please check with your local payers for specific guidelines.

1. The national average 2025 Medicare hospital outpatient rates and status indicators are from the 2025 Hospital Outpatient Prospective Payment System (OPPS) release, Addenda B, and D1 accessible at https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip. The national average 2025 Medicare ambulatory surgical center rates and payment indicators are from the 2025 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip. 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.
2. Section 70.1 of Chapter 13 of the Medicare Claims Processing Manual; available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

Radiation Treatment
Facility Payment

Status Indicator Information[1]

Status Indicator	Explanation
OPPS Status Indicators	
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
S	Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply
U	Brachytherapy sources paid as separate APC payment under OPPS
ASC Payment Indicators	
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate
N1	Packaged service/item; no separate payment made
Z2	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight
Z3	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs

Modifier Information[2]

Modifier	Description	Explanation
26	Professional component	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number
59	Distinct Procedural Service	Under certain circumstances, it may be necessary to indicate that procedure or service was distinct or independent from other non-E/M services performed on the same day
76	Repeat procedure or service by same physician or other qualified health care professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: this modifier should not be appended to an E/M service
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a basic procedure or other qualified health care professional subsequent to the original procedure or service
XE*	Separate Encounter	A service that is distinct because it occurred during a separate encounter
XP*	Separate Practitioner	A service that is distinct because it was performed by a different practitioner

1. The OPPS Payment Status Indicators for CY 2025 are from the 2025 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum D1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip. The ASC Payment Indicators for CY 2025 are from the 2025 Ambulatory Surgical Center Payment Final Rule, Addenda DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip.
2. AMA, 2025 CPT, Professional Edition; CMS 2025 HCPCS codes

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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