2025 coding & reimbursement guide

BREAST HEALTH SOLUTIONS

HOLOGIC

Breast Surgery

Physician Professional Payment

CPT®[1] Code/ HCPCS[2] Code	Description	Place-of-Service	RVU[3]	2025 National Average Medicare Rate[4]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Professional (Facility)	20.01	$647.25
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Professional (Facility)	27.49	$889.21
38500	Biopsy or excision of lymph node(s); open, superficial	Professional (Facility)	7.73	$250.04
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Professional (Facility)	13.43	$434.41
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Professional (Facility)	4.11	$132.94
76098	Radiological examination, surgical specimen	Professional (Facility)	0.45	$14.56

Facility Payment

CPT®[1] Code / HCPCS[2] Code	Description	Place-of-Service	APC[5]	Status Indicator[5]	2025 National Average Medicare Rate[5]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Hospital	5091	J1	$3,829.28
		ASC	NA	A2	$1,538.05
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Hospital	5092	J1	$6,521.46
		ASC	NA	A2	$2,682.40
38500	Biopsy or excision of lymph node(s); open, superficial	Hospital	5091	J1	$3,829.28
		ASC	NA	A2	$1,538.05
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Hospital	5091	J1	$3,829.28
		ASC	NA	A2	$1,538.05
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
76098	Radiological examination, surgical specimen	Hospital	5524	Q2	$548.30
		ASC	NA	N1	Packaged

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2. Centers for Medicare & Medicaid Services (CMS), 2025 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
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. 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.

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Modifier Information[1]

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 service was repeated by another physician 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

* Specific Modifiers for Distinct Procedural Services, CMS Transmittal 1422, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

Status Indicator Information[5]

Status Indicator	OPPS Status Indicator
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
J1	Services paid under OPPS through a Comprehensive APC, covered Part B services on the claim are packaged with the primary "J1" service for the claim, with certain exceptions
Q2	Q2 is packaged if on the same claim as a HCPCS code assigned status indicator "T"; otherwise payment is made through a separate APC payment
S	Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply
Payment Indicator	**ASC Payment Indicator**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
J8	Device-intensive procedure; paid at adjusted rate
N1	Packaged service/item; no separate payment made

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