HOLOGIC

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Contrast Enhanced Mammography & Biopsy
Coding & Reimbursement FAQ

Hologic Inc., provides this 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.

Contrast Enhanced Mammography

1. What CPT®[1] and HCPCS[2] Codes are relevant when Contrast Enhanced Mammography is performed?

When Contrast Enhanced Mammography is performed a regular 2D image is always acquired, therefore providers can report CEM as described below.

CPT®[1]/HCPCS Code[2]		Description	Place-of-Service	2024 National Average Medicare Rate[3,4,5]
Digital Mammography	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global (Office/Freestanding)	$125.16
			Professional (Facility)	$37.95
			Technical (Facility)	$87.21
	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global (Office/Freestanding)	$158.45
			Professional (Facility)	$46.60
			Technical (Facility)	$111.85
Injection	96374*	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	$36.62
			Professional (Facility)	N/A
			Technical (Facility)	$204.22
Contrast	Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Global (Office/Freestanding)	$0.137/ml
			Technical (Facility)	Packaged

2. What billing edits are pertinent for Contrast Enhanced Mammography?

CPT 2024, Professional Edition, advises, "Do not report 96365-96479 with codes for which IV push or infusion is an inherent part of the procedure (e.g., administration of contrast material for a diagnostic imaging study)." Because IV push or infusion is not an inherent part of digital mammography services, it could be appropriate to report this service in addition to a digital mammography code.

There are no National Correct Coding Initiative (NCCI) procedure-to-procedure edits pertinent to billing CPT code 96374 with the above CEM codes. Contact your local payer for specific coding and coverage guidelines.

* CPT 2024, Professional Edition, advises, "Do not report 96365-96479 with codes for which IV push or infusion is an inherent part of the procedure (e.g., administration of contrast material for a diagnostic imaging study)." Because IV push or infusion is not an inherent part of digital mammography services, it could be appropriate to report this service in addition to a digital mammography code. Consult your payer for its instructions on how to bill for contrast-enhanced mammography.
**In this circumstance, the additional work and resources associated with the CEM procedure, including injecting the contrast material, that are not part of the 2D Full Field Digital Mammography (FFDM) procedure would be described by 76499.

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3. Does Medicare pay separately for the injection (CPT code 96374; therapeutic, prophylactic, or diagnostic injection (specify substance or drug; intravenous push, single or initial substance/drug)) of contrast material when performing Contrast Enhanced Mammography?

Hospital Outpatient: Medicare provides separate reimbursement to hospitals (technical payment) for the injection of contrast material under the Outpatient Prospective Payment System. In the hospital outpatient setting, there is no additional reimbursement for the physician for the injection service.

Office/Freestanding: Medicare provides separate reimbursement for the injection of contrast material in the freestanding/office setting.

4. Does Medicare pay separately for the contrast material (HCPCS code Q9967; low osmolar contrast material, 30-399 mg/ml iodine concentration, per ml) used during Contrast Enhanced Mammography exams?

Hospital Outpatient: Medicare does not provide separate payment for Q9967 in the hospital outpatient setting because payment has been packaged with the primary procedure. Facilities should still report Q9967 to ensure that all costs associated with a procedure are captured and used when determining future payment rates.

Office/Freestanding: Medicare pays separately for contrast material, based on reported average sales price, wholesale acquisition cost, or invoice price, when furnished in physicians' offices.

5. If a patient has previously had a diagnostic mammogram, can she have a Contrast Enhanced Mammogram?

Yes. Subject to any applicable payer policy, patients can have a diagnostic mammogram and a contrast enhanced mammogram if the payer determines the medical necessity for follow up imaging. Both procedures may be subject to the patient's deductible and co-insurance.

Diagnostic mammography services do not have a global period, meaning providers do not have to wait a specific amount of time before performing another procedure.

6. How do imaging centers bill for a screening and diagnostic mammogram performed on the same day?

If a provider performs a screening mammogram and a diagnostic mammogram on the same day, the modifier GG and 59 (distinct procedural service) may be used to report the performance of both studies. Subject to guidance from a payer, providers may bill for both the screening and diagnostic mammogram on the same claim.

7. Is Contrast Enhanced Mammography considered a covered service?

Insurance coverage will vary by plan. In the absence of a plan policy for coverage of CEM, coverage is determined on a claim-by-claim basis. Medicare does not have a coverage policy regarding CEM, so coverage is determined on a claim-by-claim basis.

CEM is not covered as preventative care because it is considered a diagnostic study.

When covered as a diagnostic study, patients may be responsible for their deductible an d/or co-insurance depending on their insurance plan.

Contrast Enhanced Biopsy

8. What CPT and HCPCS Codes are relevant when Contrast Enhanced Biopsy is performed?

Contrast Enhanced Biopsy (CEB) incorporates the use of stereotactic guidance to help locate a breast abnormality, the specific tissue to be biopsied, and the administration of a contrast agent into the patient's breast tissue to obtain contrast enhanced images. Therefore, providers can report CEB in the following way:

CPT®[1]/HCPCS Code[2]		Description	Place-of-Service	2024 National Average Medicare Rate[3,4,5,6]
Stereotactic biopsy	19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Global (Office/Freestanding)	$494.32
			Professional (Facility)	$159.45
			Technical (Facility)	$1544.75
			ASC	$682.92
Injection	96374*	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Global (Office/Freestanding)	$36.62
			Professional (Facility)	N/A
			Technical (Facility)	$204.22
Contrast	Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	Global (Office/Freestanding)	$0.137/ml
			Technical (Facility)	Packaged

*Modifier 59 "distinct procedural service" may need to be appended to 96374 per discussion below.

9. What billing edits are pertinent for Contrast Enhanced Biopsy?

CPT 2024, Professional Edition, advises, "Do not report 96365-96479 with codes for which IV push or infusion is an inherent part of the procedure (e.g., administration of contrast material for a diagnostic imaging study)." Relatedly, CPT codes 19081 and 96374 are subject to a NCCI procedure-to-procedure edit; however, a modifier is allowed in order to permit billing the two codes together. Because the administration of a contrast agent during a stereotactic biopsy is a choice made by the provider and is not usually part of the procedure, use of both codes with modifier 59 appended to CPT code 96374 to identify the service as a distinct procedural service may be appropriate. Consult your payer for its instructions on how to bill for contrast-enhanced biopsy.

10. Does Medicare pay separately for the injection (CPT code 96374; therapeutic, prophylactic, or diagnostic injection (specify substance or drug; intravenous push, single or initial substance/drug)) of contrast material when performing Contrast Enhanced Biopsy?

Hospital Outpatient: Medicare may provide separate reimbursement to hospitals (technical payment) for the injection of contrast material under the Outpatient Prospective Payment System when the appropriate modifier is appended to the CPT code.

In the hospital outpatient setting, there is no additional reimbursement for the physician for the injection service.

Office/Freestanding: Medicare may provide separate reimbursement for the injection of contrast material in the office/freestanding setting when the appropriate modifier is appended to the CPT code.

11. Does Medicare pay separately for the contrast material (HCPCS code Q9967; low osmolar contrast material, 30-399 mg/ml iodine concentration, per ml) used during Contrast Enhanced Biopsy?

Hospital Outpatient: Medicare does not provide separate payment for Q9967 in the hospital outpatient setting because the payment is packaged with the primary procedure. Facilities should still report Q9967 to ensure that all costs associated with a procedure are captured.

Office/Freestanding: Medicare pays separately for contrast material, based on reported average sales price, wholesale acquisition cost, or invoice price, when furnished in physicians' offices.

Contrast Enhanced Mammography & Contrast Enhanced Biopsy

12. What reimbursement resources does Hologic provide?

We understand how important it is to deliver advanced testing, imaging and treatment solutions that bring greater certainty to clinicians – and make a real difference in the lives of patients looking for answers. That's why we stand behind our innovative solutions, with information to assist our customers as well as providing access to a coding and reimbursement service through an independent third party certified and Health Insurance Portability and Accountability Act (HIPAA) compliant coding company.*

The Pinnacle Health Group provides reimbursement and coding support through a staff of professional certified coders and can address the following:

- Coding Questions
- Insurance Coverage
- Private Payer Contracted Rates (PPR)
- Patient Benefit Verification
- Patient Pre-authorization / Pre-certification
- Claims Appeals and Denials
- HIPAA Compliance Support

Telephone: 866.369.9290
Email: hologic@thepinnaclehealthgroup.com
Available Monday-Friday 8:30am – 6:00pm EST
***Response from Pinnacle Health Group may take 2–3 business days.**

1. American Medical Association (AMA), 2024 Current Procedural Terminology (CPT), Professional Edition. CPT copyright 2023 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

2. Centers for Medicare & Medicaid Services (CMS), 2024 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCSQuarterly-Update.

3. The national average 2024 Medicare rates to physicians shown are based on the 2024 conversion factor of $33,2875 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2024 is 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. The national average Medicare rate to physicians for Q9967 comes from the April 2024 ASP Pricing File, available at https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files, and is subject to subsequent pricing files.

4. The 2024 physician relative value units (RVUs) are from the 2024 Physician Fee Schedule (PFS) Relative Value Files, file RVU24B, available from the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu24b.

5. The national average 2024 Medicare Technical (Facility) rates for CPT codes 76499 and 96374 and HCPCS code Q9967 can be found in the April 2024 Hospital Outpatient Prospective Payment System (OPPS) release, Addendum B accessible at https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/april-2024-0.

6. The national average 2024 Medicare ambulatory surgical center rates and payment indicators are from the 2024 Ambulatory Surgical Center Payment Final Rule, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip.

7. https://densebreast-info.org/legislative-information/state-legislation-map.