



2025 Coding and Reimbursement Guide for Breast Imaging



GE HealthCare

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Procedures

Current Procedural Terminology (CPT®) Coding for Mammography and Breast Ultrasound

The following table provides CPT coding and description of mammographic and ultrasound breast imaging services for screening, diagnostic, and biopsy purposes as a 2025 Medicare unadjusted national average, which does not reflect specific geographic location.

CPT® Code	Description	2025 Medicare Physician Fee Schedule		2025 Medicare HOPPS	
		Facility & Non-Facility Payment [4]	APC[5]	Medicare HOPPS[5]	
Mammography - Screening					
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Global	\$124.53	These services are paid by MACs using a payment system other than OPSS. Status indicator = A	
		TC	\$89.60		
		26	\$34.93		
+77063	Screening digital breast tomosynthesis (DBT), bilateral List separately in addition to code for primary procedure)	Global	\$50.78		
		TC	\$23.29		
		26	\$27.49		
Mammography - Diagnostic					
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Global	\$121.95	These services are paid by MACs using a payment system other than OPSS. Status indicator = A	
		TC	\$85.07		
		26	\$36.88		
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global	\$153.65		
		TC	\$108.36		
		26	\$45.29		
+G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)	Global	\$42.70		
		TC	\$15.20		
		26	\$27.49		
Breast Ultrasound - Screening and Diagnostic					
76641	Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; complete	Global	\$98.98	5522	\$106.34
		TC	\$65.34		
		26	\$33.64		
76642	Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; limited	Global	\$82.16	5521	\$88.05
		TC	\$50.78		
		26	\$31.38		

Procedures

CPT® Code	Description	2025 Medicare Physician Fee Schedule		2025 Medicare HOPPS	
		Non-facility Payment[4]	Facility Payment[4]	APC[5]	Medicare HOPPS[5]
Breast Biopsy with Image Guidance					
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	\$470.97	\$155.91	5072	\$1,620.24
+19082	... each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	\$358.40	\$77.96	Status Indicator =N (No separate APC payment)	
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	\$465.79	\$146.53	5072	\$1,620.24
+19084	... each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	\$351.61	\$73.75	Status Indicator =N (No separate APC payment)	

Procedures

Contrast-Enhanced Mammography (CEM)

When contrast is utilized with mammography, the procedure is reported by the primary diagnostic mammogram procedure code (i.e., 77065 or 77066). See table below for a potential coding scenario to include IV push and contrast material.

CPT® Code	Description	2025 Medicare Physician Fee Schedule		2025 Medicare HOPPS	
		Facility & Non-Facility Payment [4]	APC[5]	Medicare HOPPS[5]	
Contrast-Enhanced Mammography					
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral or	Global	\$121.95	These services are paid by MACs using a payment system other than OPPS.	
		TC	\$85.07		
		26	\$36.88		
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Global	\$153.65	Status indicator = A	
		TC	\$108.36		
		26	\$45.29		
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	\$33.96		5693	\$210.69
HCPCS[3] Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	ASP (Average Sales Price) Fee Schedule [4] = \$0.144 per ml		Status Indicator =N (No separate APC payment)	

CPT® Code	Description	Non-facility Payment[4]	Facility Payment[4]	APC[5]	Medicare HOPPS[5]
Contrast- Enhanced Mammography Guided Biopsy					
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	\$470.97	\$155.91	5072	\$1,620.24
+19082	... each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	\$358.40	\$77.96	Status Indicator =N (No separate APC payment)	
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single of initial substance/drug	\$33.96	\$33.96	5693	\$210.69
HCPCS[3] Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	ASP (Average Sales Price) = \$0.121 per ml		Status Indicator =N (No separate APC payment)	

Procedures

Magnetic Resonance Imaging (MRI)

The following section includes guidance for sites using Breast MRI and/or Breast MRI guided biopsy.

CPT® Code	Description	2025 Medicare Physician Fee Schedule		2025 Medicare HOPPS	
		Facility & Non-Facility Payment [4]	APC[5]	APC[5]	Medicare HOPPS[5]
Breast MRI					
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Global	\$208.63	5523	\$241.72
		TC	\$65.66		
		26	\$142.97		
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Global	\$215.10	5523	\$241.72
		TC	\$142.32		
		26	\$72.78		
C8903	Magnetic resonance imaging with contrast, breast; unilateral			5571	\$178.02
C8906	Magnetic resonance imaging with contrast, breast; bilateral			5572	\$357.13
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	\$330.58	USE C8905 (below)	
		TC	\$234.19		
		26	\$96.39		
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral			5572	\$357.13
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	\$336.73	USE C8908 (below)	
		TC	\$231.28		
		26	\$105.45		
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral			5572	\$357.13

Procedures

CPT® Code	Description	2025 Medicare Physician Fee Schedule		2025 Medicare HOPPS	
		Non-Facility Payment [4]	Facility Payment [4]	APC[5]	Medicare HOPPS[5]
Breast Biopsy with MR Guidance					
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	\$711.95	\$171.44	5072	\$1,620.24
+19086	...each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	\$547.63	\$85.39	Status Indicator =N (No separate APC payment)	

Reimbursement Terminology

Current Procedural Terminology (CPT®) Codes

CPT® coding system[1], developed by the American Medical Association, describes the healthcare provider's service and/or procedure being performed.

Healthcare Common Procedure Coding System (HCPCS)

The HCPCS is a standardized coding system[3] used primarily to report products, supplies, injections and services, prosthetics, orthotics, i.e., contrast agents are identified by HCPCS

ICD-10-CM (Clinical Modification)

These codes for diagnosis are used by all providers in every healthcare setting. It is developed and maintained by the Centers for Disease Control & Prevention, National Center for Health Statistics[8]. Select the ICD-10-CM code based on the signs, symptoms, or conditions that reflect the reason for doing the mammography.

ICD-10-PCS (Hospital Inpatient Procedure Coding)

The ICD-10 Procedure Coding System (ICD-10-PCS) is a catalog of procedural codes used for hospital inpatient healthcare settings[8]. CMS maintains the catalog releasing yearly updates. The following are ICD-10-PCS procedure codes that are typically used to report radiological procedures for mammography services.

- BH00ZZZ Plain radiography of right breast
- BH01ZZZ Plain radiography of left breast
- BH02ZZZ Plain radiography of bilateral breasts

Modifiers

A code that indicates a healthcare procedure was modified without changing the definition of the CPT code set. Consult the Medicare Claims Processing Manual Online [2] for proper application. Here are common modifiers related to the radiologic procedures.

JW and JZ: drug wastage requires a modifier for Medicare claims. When contrast media in single-use vials are used in IDTFs, the modifiers are expected, and may cause claim delays if missing. JW/JZ do not apply in HOPPS billing, as contrast media is packaged.

26 - Professional component: The amount listed in physician fee schedule to be paid for the radiologist's interpretation and report.

TC - Technical component: The amount listed in physician fee schedule to be paid for performing the service (includes staffing and equipment costs). Used mainly by IDTFs.

GG: designates the performance and payment of a screening mammogram and diagnostic mammogram on the same patient and on the same day.

50 - Bilateral Procedure: Do not use this modifier when the CPT code is already defined as bilateral, as it is expected to be performed on both sides.

Ambulatory Payment Classifications (APCs) (Medicare only)

In the hospital outpatient setting, the CPT codes are grouped into an APC when procedures are deemed clinically homogeneous. Under APCs, hospitals are paid per encounter, and reimbursement rate is published in the fee schedule[5,6]

Payment

The amount that a payer renders to a healthcare entity for covered therapies and services. The payment methodology and amount vary based on where the care is provided.

Hospital Outpatient Prospective Payment System (HOPPS)

CMS administers the program which sets payment rates for designated hospital outpatient services. CMS issues quarterly updates on APC assignment and reimbursement rates. This information is only available on the CMS website. [5,6]

Medicare Coverage Determinations

Medicare coverage is limited to services that are "reasonable and necessary" for the diagnosis or treatment of an illness. National Coverage Determinations(NCDs) are created through an evidence-based process with opportunities for public input. Some NCDs include mammograms and image guided breast biopsies. In the absence of NCD, the service may be covered at the discretion of the Medicare Administrative Contractor (MAC) based on a local coverage determination.

Payment Considerations

Commercial/Private Payers

Each commercial payer determines its own coverage policies. Commercial payers may implement restrictions and/or specific criteria. Coverage may also vary based on the patient's benefits or on the negotiated contract between the providers and the payer. Some payers have formal, published policies and others use Medical Benefit Managers to write the policies and decide appropriate use.

Medicare Payment Methodologies for Mammography Services

Medicare reimburses for mammography services when the services are within the scope of the provider's license and are deemed medically necessary. Regardless of the site of service, screening and diagnostic mammography services are paid under the Medicare physician fee schedule [6]

Medicaid

Each Medicaid program is administered by its particular state. That state determines its own specific coverage policies or guidelines. Medicaid coverage may also vary by provider type, setting of care, and the type of Medicaid plan the patient has, i.e., fee-for-service, managed Medicaid

Physician Offices, Free-standing, and Independent Diagnostic Testing Facilities (IDTFs)

Reimbursement for physician offices and IDTFs is based on the CPT code used to report the service provided. Medicare assigns

Relative Value Units (RVUs) to each CPT. This takes into account the physician's work, practice expenses (overhead), and malpractice expenses associated with a procedure. The RVUs are then converted to a standard payment rate per procedure and are adjusted geographically. Contrast agents are billed separately from the imaging procedure in the freestanding facility for both Medicare and commercial payers. In the office setting, a physician who owns the radiology equipment and performs the service may report the global code without a 26 modifier.

Hospital Outpatient Setting

When a breast imaging service is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare, because the global charge includes both the professional (26) and technical component (TC) of the service. If the procedure is performed in the hospital outpatient setting, the hospital may bill for TC of the mammography service as an outpatient service.

Hospital Inpatient Setting

Inpatient scans would be considered part of the payment made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services.

	Hospital Outpatient Department	Independent Diagnostic Testing Facilities
Medicare	APC (Ambulatory Payment Classification) [5,6]	Per fee schedule, typically for each code[4]
Medicare Advantage	Per contract, typically for each code	Per contract, typically for each code
Commercial	Per contract, typically for each code	Per contract, typically for each code

Support Services

GE HealthCare Reimbursement Support Line

GE HealthCare is pleased to offer toll-free customer support for coding and reimbursement questions related to our products. Please contact us at 800 767 6664.

Customer Service

To place an order, call 800 292 8514.

Medical Affairs

For technical or product-related questions and/or to reach a Clinical Applications Specialist, call 800 654 0118 (option 2, then option 3) or email medical.affairs@gehealthcare.com.

Disclaimers

2025 Coding and Reimbursement Guide

This 2025 Coding Guide for Breast Imaging is intended to provide available current reimbursement information but it is not an all-inclusive resource. The Medicare reimbursement amounts shown are currently published national average payments. Actual reimbursement will vary for each provider and institution based on geographic differences in labor and non-labor costs, hospital teaching status, proportion of low-income patients, coverage, and/or payment rules. Healthcare providers and hospitals identify diseases, procedures, drugs, devices, and other healthcare-related items provided to patients through various coding systems. The existence of CPT® and HCPCS codes does not guarantee coverage. This document is not an official coding resource and should never have any influence on clinical decisions. All payers have their own unique medical policies and guidelines. It is important that you review and adhere to each relevant payer policy.

CPT® Disclaimer

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Regulation (FAR) and Defense Federal Acquisition Regulation Supplement (DFARS) Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. GE HealthCare does not promote the use of its products outside their FDA-approved label.

GE HealthCare Disclaimer

Third party reimbursement amounts and coverage policies for specific procedures will vary by payer, time period, locality, and type of provider entity. This document is not intended to interfere with the healthcare professionals independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The health care provider has the responsibility to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or health care consultant or experienced legal counsel.

SOURCES:

[1] CPT® 2025 Professional Edition American Medical Assn; 1st edition (October 08,2024) ISBN-10: 978-1-64016-304-1. Accessed January 16, 2025

[2] Medicare Claims Processing Manual. <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912>

[3] Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services. <https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update>

[4] 2025 Medicare Physician Fee Schedule. CMS-1784-F. <https://www.cms.gov/medicare/payment/fee-schedules/physician> CY2025 Conversion Factor of \$32.3465 PFS Look-Up Tool <https://www.cms.gov/medicare/physician-fee-schedule/search> Accessed January 6, 2025

[5] Medicare HOPPS 2025 Fee Schedule Addendum B. <https://www.cms.gov/license/ama?file=/files/zip/january-2025-ops-addendum-b.zip> Accessed January 6, 2025

[6] Code of Federal Regulations: Hospital Outpatient Prospective Payment System. CMS-1809-FC. <https://www.cms.gov/medicare/payment/prospective-paymentsystems/hospital-outpatient/regulations-notices/cms-1809-fc>

[7] Code of Federal Regulations: Hospital Inpatient Prospective Payment System. CMS-1808-IFC. <https://www.cms.gov/medicare/payment/prospective-paymentsystems/acute-inpatient-pps/fy-2025-ipp-final-rule-home-page>

[8] CMS 2025 ICD-10 Procedure Coding System (ICD-10-PCS). <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-pcs>

