



# Reimbursement Information for Automated Breast Ultrasound Screening

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## ABUS Implementation Resources

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The Invenia™ ABUS is indicated as an adjunct to mammography for breast cancer screening in asymptomatic women for whom screening mammography findings are normal or benign (BI-RADS® Assessment Category 1 or 2), with dense breast parenchyma (BI-RADS Composition/Density C or D), and have not had previous clinical breast intervention. The device is intended to increase breast cancer detection in the described patient population. The Invenia ABUS may also be used for diagnostic ultrasound imaging of the breast in symptomatic women.

## Current Procedural Terminology (CPT)®<sup>1</sup> Coding and Medicare Reimbursement

The following table provides CPT®<sup>1</sup> coding for ABUS and 2022 Medicare national average reimbursement for physician and hospital outpatient settings of care. Payment will vary by geographic location. *Note: Payment rates may reflect DRA-imposed payment reductions for services that are subject to the regulations.*

### 2022 Medicare reimbursement for procedures related to breast ultrasound (Reflects national rates, unadjusted for locality)

CPT® <sup>1</sup> Code/Description	Reimbursement Component	Medicare Freestanding Facility/Physician Office Payment <sup>2</sup>	Medicare Hospital Outpatient Payment <sup>3</sup>	
<b>CPT 76641*</b> Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Technical <sup>***</sup>	\$71.63	<b>APC 5522</b>  Status Indicator = Q1**	\$111.19
	Professional <sup>****</sup>	\$35.64		
	Global	\$107.28		
<b>CPT 76642*</b> Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Technical <sup>***</sup>	\$54.68	<b>APC 5521</b>  Status Indicator = Q1**	\$82.61
	Professional <sup>****</sup>	\$33.22		
	Global	\$87.90		

\* Four-quadrant and retroareolar region imaging required for “complete” examination. Axilla imaging may or may not be performed.

\*\* The STVX-packaged codes (status indicator Q1) are packaged when billed on the same date of service with any other code with a status indicator of S, T, V, or X. If not, they are separately payable under a separate APC. If you report more than one STVX- or T-packaged code without a separately payable service into which it would otherwise be packaged, CMS makes separate payment only for the highest-paying service and packages all others into that code. Reference information may be found at the online resource: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance>

\*\*\* Technical (-TC) – The technical component is the equipment and technician performing the test. This is identified by adding modifier “TC” to the procedure code identified for the technical component charge.

\*\*\*\* Professional (-26) – The professional component is the interpretation of the results of the test. When the professional component is reported separately, the service may be identified by adding modifier “26.”

Payment rates for Medicaid as well as Private (non-Medicare) payers will vary by insurer as well as individual contractual agreements. It is always recommended to check with your payer for coding, coverage and reimbursement requirements.

## Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of ultrasound for breast procedures.

### 26 – Professional Component

A physician who performs the interpretation of an ultrasound exam in the hospital outpatient setting may submit a charge for the professional component of the ultrasound service using a modifier (-26) appended to the ultrasound code.

### 50 – Bilateral Procedure

This modifier would be used to bill bilateral procedures that are performed at the same operative session, unless otherwise identified in the listings. To appropriately adjust payment when bilateral procedures are furnished under the PFS, payments are adjusted to 150 percent of the unilateral payment when a service has a bilateral payment indicator assigned.

### TC – Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

## ICD-10-CM and ICD-10-PCS

ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes were implemented October 1, 2015. It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the mammography. Examples are provided of ICD-10-CM diagnosis and ICD-10-PCS procedure codes that relate to breast ultrasound procedures for breast cancer screening.

### ICD-10-CM (diagnosis)

- R92.0 Mammographic microcalcification found on diagnostic imaging of breast
- R92.1 Mammographic calcification found on diagnostic imaging of breast
- R92.2 Inconclusive mammogram
- R92.8 Other abnormal and inconclusive findings on diagnostic imaging of breast
- Z12.39 Encounter for other screening for malignant neoplasm of breast

### ICD-10-PCS (procedure)

- BH40ZZZ Ultrasonography of Right Breast
- BH41ZZZ Ultrasonography of Left Breast
- BH42ZZZ Ultrasonography of Bilateral Breasts

For more information on ICD-10-CM/PCS, please go to: <https://www.cms.gov/medicare/Coding/ICD10/index.html>

## Documentation Requirements<sup>4</sup>

Ultrasound performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet all the following requirements:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient's medical record

A separate written record of the diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record. This should include a description of the structures or organs examined the findings and reason for the ultrasound procedure. Diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

*Note: The description of the new code 76641 states that axilla imaging is not required, but included in the code description if performed. Therefore, if this is part of the examination, it should be documented in the patient files that it was performed.*

## Payment Methodologies for Ultrasound Services

Medicare may reimburse for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

### Site of Service

#### Physician Office Setting

In the office setting, a physician who owns the ultrasound equipment and performs the service, or a sonographer who performs the service, may report the global code without a -26 modifier.

#### Hospital Outpatient

When the ultrasound is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service.

If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the ultrasound service as an outpatient service.

The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

#### Hospital Inpatient Setting

Although this service would not typically be performed in the inpatient hospital setting, if it is performed in this setting, charges for the ultrasound services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless.

*Note: Medicare may reimburse for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.*

## Coverage information

Procedures may be a covered benefit if such usage meets all requirements established by the particular payer. However, it is advisable that you verify coverage policies with your local Medicare Administrative Contractor. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record. Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform ultrasound services. Some private payer plans will reimburse for ultrasound procedures performed by any physician specialist while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, plans may require providers to submit applications requesting these diagnostic ultrasound and ultrasound-guided services be added to the list of services performed in their practice. It is important that you contact the payer prior to submitting claims to determine their requirements.

1. CPT codes and descriptions only are copyright © 2021 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.
2. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment amounts indicated are based upon data elements published in the Federal Register, CMS-1751-F/November 19, 2021 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2022 through 12/31/2022. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
3. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the Hospital Outpatient Prospective Payment System, as published in the Federal Register, CMS-1753-FC/November 16, 2021 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2022 through 12/31/2022. CMS may make adjustments to any or all of the data inputs from time to time. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
4. Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations to prove that they have undergone training through recent residency training or post-graduate CME and experience. For further details, contact your Medicare contractor.

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Please see inside pocket for Full Product Information.

### ABUS Reimbursement Hotline Services

GE Healthcare agrees to abide by the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other relevant state or federal privacy laws and regulations concerning the use and/or disclosure of protected health information during the course of providing this support.

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