2024 Imagio® Breast Imaging
Coding and Reimbursement Guide

OA/US Breast Imaging System

Imagio® Breast Imaging System

The Imagio® Breast Imaging System is indicated for use by a trained and qualified healthcare provider for evaluation of palpable and non-palpable breast abnormalities in adult patients who are referred for a diagnostic imaging breast workup following clinical presentation, screening or diagnostic mammography, or other imaging examinations. Masses classified as BI-RADS categories 3 through 5 can be assessed using the opto-acoustic (OA) mode. The OA mode is not indicated for ultrasound BI-RADS 1 and 2 findings.

CPT Coding and Payment for Hospital Outpatient and Physicians

Effective January 1, 2024, the American Medical Association established CPT code 0857T *Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (list separately in addition to code for primary procedure)* for use in reporting OA imaging.

The following coding and payment information is specific to hospital outpatient, freestanding facility (e.g., independent diagnostic testing facility), and physician office-based procedures. Coding represents breast ultrasound and OA imaging. This is not a comprehensive list of all available codes, and it is possible that there is a more appropriate code for any given procedure. Medicare rates referenced are national payment amounts effective January 1, 2024, and predicated on respective CPT[1] codes and mapped ambulatory payment classifications (APCs). Payment amounts may vary and are based on locality.

2024 Coding and Payment

CPT	Descriptor	Hospital Outpatient			Freestanding Facility & Physician Office Payment*		
		APC	Payment	SI***	Professional (26)	Technical (TC)	Global
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete**	5522	$104.75	Q1	$33.73	$67.13	$100.85
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	5521	$86.58	Q1	$31.43	$52.06	$83.50
0857T	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (list separately in addition to code for primary procedure)	5522	$104.75	S	Medicare Contractor Priced****		

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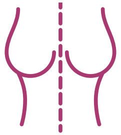
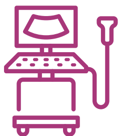
Modifiers

A coding modifier is two characters (letters or numbers) appended to a CPT or HCPCS Level II code. The modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code. For purposes of billing breast ultrasound and OA imaging procedures, the following may apply.



50 – Bilateral Procedure
This represents a service or procedure performed on both sides of the body during the same session. To adjust payment for a bilateral procedure furnished under Medicare's Physician Fee Schedule, payment is adjusted to 150 percent of the unilateral payment.

26 – Professional Component
This represents work done by a physician to interpret an ultrasound and/or OA imaging exam when the physician/professional group does not own the equipment used to perform the procedure. Appending this modifier to an ultrasound code and/or OA imaging code will solicit payment only for the professional component of a procedure code. See 2024 Coding and Payment table as example.



TC – Technical Component
This modifier is used to bill for the services of the owner of the equipment used to perform an ultrasound and/or OA imaging exam. Appending this modifier to an ultrasound code and/or OA imaging code will solicit payment only for the technical component of a procedure code. See 2024 Coding and Payment table as example.

Diagnosis Coding Guidance

ICD-10-CM codes are used for indicating diagnoses and must be reported to justify procedures performed. It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary and must meet payer criteria specified for determination.

Based on indications, the following may be appropriate codes to report for breast imaging procedures post screening or diagnostic mammography, or other imaging examinations.

ICD-10 codes covered if selection criteria are met (Diagnostic):

ICD-10 Code	Diagnosis
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.929	Malignant neoplasm of breast
C79.2	Secondary malignant neoplasm of skin [of breast]
C79.81	Secondary malignant neoplasm of breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.92	Carcinoma in situ of breast
D24.1	Benign neoplasm of right breast
D24.9	Benign neoplasm of breast
D48.60	Neoplasm of uncertain behavior of unspecified breast

ICD-10 codes covered if selection criteria are met (Diagnostic) continued:

ICD-10 Code	Diagnosis
D48.62	Neoplasm of uncertain behavior of breast
N60.01	Solitary cyst of right breast
N60.99	Benign mammary dysplasia
N63.0	Unspecified lump in unspecified breast
N63.42	Unspecified lump in unspecified breast [breast nodules]
N65.1	Disorders of breast
Q85.82	Other Cowden syndrome
Q85.83	Von Hippel-Lindau syndrome
Q85.89	Other phakomatoses, not elsewhere classified
R92.0	Mammographic microcalcification found on diagnostic imaging of breast
R92.8	Abnormal and inconclusive findings on diagnostic imaging of breast
R92.2	Inconclusive mammogram
R92.8	Other abnormal and inconclusive findings on diagnostic imaging of breast
Z12.31	Encounter for screening mammogram for malignant neoplasm of breast
Z15.01	Genetic susceptibility to malignant neoplasm of breast [Fraumeni syndrome]
Z80.3	Family history of malignant neoplasm of breast
Z84.81	Family history of carrier of genetic disease
Z85.3	Personal history of malignant neoplasm of breast
Z86.000	Personal history of in-situ neoplasm of breast
Z92.3	Personal history of irradiation

Documentation

It is important for billing purposes that each claim be supported by appropriate coding supported by the medical record. Specificity of work performed will aid in supporting the claim, e.g., unilateral vs. bilateral, and should help with determining appropriate payment. Other documentation requirements, such as physician referral and medical necessity determination, are to be maintained by the provider as part of the patient's medical record. This information may be requested to determine appropriate reimbursement of an individual claim.

Patient Access Support

Seno Medical has partnered with The Pinnacle Health Group for supporting patient access to Imagio® Breast Imaging System procedures.

General References

1. CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule (CMS-1786-FC); Addendum B.
2. CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1784-F); Addendum B. Medicare physician fee payments were derived from https://www.cms.gov/medicare/physician-fee-schedule/search (sourced: 1/30/2024).

CY 2024 Imagio® Breast Imaging
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For additional reimbursement support, please contact:

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Coding and reimbursement information provided by Seno Medical is gathered from third-party sources and is subject to change without notice. This information is provided for illustrative and educational purposes only and does not constitute reimbursement or legal advice. It is always the provider's responsibility to determine medical necessity, proper site for delivery of any service, and to submit appropriate codes, charges, and modifiers for services rendered. Seno Medical and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. Contact your local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change and will vary by payer and region. To the extent that you submit cost information to Medicare, Medicaid, or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. Medicaid and private insurer payments will vary by insurer and may be predicated on contracted rates. It is advisable to check with your payer for coding, coverage, and reimbursement requirements. Seno Medical does not promote the use of the Imagio® Breast Imaging System outside their FDA-approved label.

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*Medicare Physician Fee Schedule.
**Complete. Four-quadrant and retroareolar region imaging required for "complete" examination. Axilla imaging may or may not be performed.
***Status Indicator. This is a payment indicator identifying how each CPT is paid for hospital outpatient. Q1 represents a packaged procedure when billed on same date of service with a procedure that has a status indicator S. S represents hospital outpatient paid; not subject to multiple procedure discounts.
****Carrier Priced. Payment is determined by Medicare Administrator Contractor (MAC). Because payment for CPT 0857T is contractor priced for freestanding facilities and physicians, providers may want to request crosswalking CPT 0857T to CPT 76812 (diagnostic mammography, including CAD when performed; unilateral). Alternatively, providers may select another code of their choosing.

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