

What surgeons should know about...

Coding breast procedures and other cancer operations

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Proper coding for breast procedures is complicated because of the many ways the care for such cases can progress. For example, biopsies are sometimes performed on two or more lesions in the same session, or a visit to discuss the next steps in treatment may occur during the postoperative period of the biopsy. To receive reimbursement, it is necessary in both instances to indicate that these procedures are distinct.

This article describes in detail both diagnostic and procedural coding for breast biopsies, excision of benign breast lesions, lumpectomies, and mastectomies with special attention to reporting multiple procedures and the use of other modifiers. Although the focus of this article is on breast procedures, many of the same problems occur when billing for other cancer operations.

This article is written for both surgeons and staff who prepare claims and presents the normal *International Classification of Diseases (ICD-9-CM)* and *Current Procedural Terminology (CPT)* rules. Of course, if a payor has specified different rules, follow those rules for claims submitted to that insurer. Be sure to retain the rules so that you can demonstrate why you are not following the normal CPT or ICD-9-CM rules.

Breast biopsies

Code 19101 is used to report an open, incisional biopsy. The remaining breast biopsy codes are for minimally invasive procedures. Code 19100 is used to report a percutaneous core needle biopsy done without image guidance and code 19102 is used to report the same procedure but with imaging guidance. Code 19103, *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guid-*

ance, is for reporting biopsies performed with either the advanced breast biopsy instrument or Mammotome machines. It is appropriate to report image guidance with code 19103 if the surgeon performs the procedure.

Localization clip or wire

At times the surgeon may choose to do a biopsy and, at the same operative session, leave a metallic localization clip so that the site may be found later if it is necessary to remove more tissue. The placement of a clip is reported using add-on code 19295, *Image guided placement, metallic localization clip, percutaneous, during breast biopsy*. Report code 19295 for each lesion that is marked with a clip, and report the imaging guidance if the surgeon does the guidance. The additional work of placing the clip is negligible, but the code is intended to assist in recovering the expense of the clip if the surgeon incurs it. Therefore, code 19295 may not be paid if the procedure is performed in a facility where the institution bore the cost of the clip.

Another technique used for marking a lesion is the immediate preoperative placement of a localization wire, which is reported using code 19290, *Preoperative placement of needle localization wire, breast*. If additional wires are placed in other lesions, use add-on code 19291 for each lesion that is marked.

Excision and mastectomy

Code 19120, *Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), open, male or female, one or more lesions*, is used for the removal of a breast lesion that is usually palpable or identified by means other than "preoperative placement of a radiological marker." It is done with an incision and involves the com-

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plete gross removal of a lesion that may be benign or malignant, in males or females. Code 19120 is for the simple removal of a mass.

When a breast lesion or mass requires localization by the preoperative placement of a radiological marker, the excision of the first lesion or mass is coded as 19125, *Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion*. Each additional lesion localized by a different radiological marker is coded with the add-on code 19126. Obviously, radiological guidance is always used for these procedures and is reported by the surgeon if he or she does the guidance.

Code 19160, *Mastectomy, partial*, is used in the surgical treatment of a breast malignancy when conservative management is chosen. Documentation in the operative report should indicate that the mass or lesion is removed with attention to obtaining adequate margins of uninvolved breast tissue appropriate for the lesion. If an axillary dissection is performed in conjunction with the partial mastectomy, code 19162, *Mastectomy, partial; with axillary lymphadenectomy*, should be used.

The classic radical, Urban type radical, and modified radical mastectomy procedures are coded 19200, 19220, and 19240, respectively. Table 1 on this page provides the complete descriptors for the three codes. The most common procedure, code 19240, applies to complete surgical removal of the breast and axillary lymph nodes. Code 19240 is differentiated from code 19200 in that the pectoralis major muscle is not removed. Code 19240 is used regardless of whether the pectoralis minor muscle is removed.

Sentinel lymph node biopsy

Sentinel lymph node biopsy is coded using the injection code 38792, *Injection procedure; for identification of sentinel node*, to report the work of injecting radiotracer or blue dye, and the appropriate lymph node excision code. The node excision codes, 38500 or 38525, are used as appropriate for the axilla. The full descriptor for code 38500 is *Biopsy or excision of lymph node(s); open, superficial*, and the full descriptor for code 38525 is *Biopsy or excision of lymph node(s); open, deep axillary node(s)*. If the lymph node being excised is a cervical lymph node, code 38510, *Biopsy or excision of lymph node(s); open,*

Table 1. Complete descriptor for mastectomy codes

CPT code	Complete descriptor
19200	Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19220	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19240	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

deep cervical node(s), is used. If it is an internal mammary lymph node, code 38530, *Biopsy or excision of lymph node(s); open, internal mammary node(s)*, is appropriate.

Reconstructive surgery

Sometimes reconstruction takes place in the same operative session as the mastectomy. Either one surgeon or two—a general or breast surgeon and a reconstructive surgeon—may be involved. When two surgeons operate, the general or breast surgeon reports the mastectomy and the reconstructive surgeon reports the appropriate reconstructive procedure. Each surgeon writes separate operative notes for his or her portion of the surgery.

Global period services

Often services are provided during the global surgery period but are unrelated to previous surgery. The most obvious example is an office visit to explore treatment options during the postoperative period of a positive breast biopsy. In this instance, report the appropriate office visit, established patient, with a modifier indicating an unrelated evaluation and management (E/M) service by the same physician during a postoperative period (modifier -24).

Treatment after biopsy

Sometimes a breast tumor is excised during the global period of the biopsy, or a re-excision may be done during the global period of the initial tumor excision. If either situation occurs, report the initial procedure as usual, and report the second procedure with a modifier to indicate a staged or related procedure by the same physician during the postoperative procedure (modifier -58). The full text for this modifier says it should be used if the second procedure was: “(a) planned prospectively at the time of the original procedure (staged); (b) more extensive than the original procedure; or (c) for therapy following a diagnostic surgical procedure.”

In the case of surgical treatment following a biopsy, the operative note should state, as part of the indications and findings, that the latter procedure is for therapy following a diagnostic surgical procedure. Documentation for a “re-excision” and the use of the -58 modifier should: (a) include reference in the indications and findings of the first procedure that, if final margins are unsatisfactory, a subsequent procedure is planned; or (b) include a discussion in the indications and findings of the second procedure that surgery more extensive than the original procedure is indicated by the final or permanent pathological findings.

Imaging guidance

We have, in several instances, simply said that if the surgeon performs imaging guidance, it is appropriate to report the imaging guidance code along with the code for the breast surgery. The various breast procedures and associated imaging guidance codes (with their full descriptors) are shown in Table 2 (p. 11). The imaging guidance codes are structured quite differently, with some specific to breast procedures and others used for a wider range of procedures. Code 76095 is reported once for each lesion located. Codes 76096 and 76942 are reported twice if two or more lesions are located bilaterally. Codes 76360 and 76393 are only reported once regardless of how many lesions are located.

The College spends considerable time and effort helping surgeons become fully trained and credentialed to perform ultrasound procedures. To ensure that surgeons who use ultrasound are quali-

fied and that the ultrasound facilities and equipment they use are appropriate for the medical application and meet and maintain quality standards, a voluntary verification process has been made available to Fellows.

Nevertheless, the College has received reports from Fellows around the country that they are routinely denied payment for ultrasound-guided breast examinations and biopsies. We recently wrote to a large number of insurers who have denied claims, asking them about their policies for reimbursing ultrasound procedures. So far, the overwhelming majority of replies have been positive. We will be following up with those who have not responded and with a handful of insurers whose responses were unsatisfactory.

Multiple procedures

To properly and completely report what the surgeon did, many claims will contain multiple procedures performed at a single setting. It is important to select the correct modifier and to understand the way CPT expects payors to set fees. A multiple procedure may or may not be reported with a multiple procedure modifier (modifier -51). When it is reported as a multiple procedure, the code is reduced in price by the insurance company. On the other hand, an add-on procedure code can never be reported without an associated base procedure. Therefore, the procedure is priced at its “true value,” is not reduced, and is not reported with a modifier. The following rules may help in selecting the correct modifier(s):

- Report separately each incision made or each lesion biopsied percutaneously. Do *not* report separately when more than one biopsy is performed through a single incision.
- Report only the definitive procedure when, in a single setting, a biopsy is taken, followed immediately by a frozen section, and then the full tumor is removed.
- Use a multiple-procedure modifier (modifier -51) when there are multiple lesions that are not bilateral. Individual Medicare carriers, and perhaps some private payors, may prefer the modifier for the right side of the body (modifier -RT) or left side of the body (modifier -LT).
- For Medicare, report the codes in the order of descending relative values and attach the

Table 2. Breast procedures and associated imaging procedures

Breast procedures		Imaging procedures	
19102	Biopsy of breast; percutaneous, needle core, using imaging guidance	76095	Stereotactic localization guidance for breast biopsy or needle placement (e.g. for wire localization or for injection), each lesion, radiological supervision and interpretation
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	76096	Mammographic guidance for needle placement, breast (e.g. for wire localization or for injection), each lesion, radiological supervision and interpretation
		76360	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation
		76393	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation
		76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	76095	Stereotactic localization guidance for breast biopsy or needle placement (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation
+ 19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	76096	Mammographic guidance for needle placement, breast (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation
19290	Preoperative placement of needle localization wire, breast	76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
19291	Preoperative placement of needle localization wire, breast; each additional lesion		

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multiple procedure modifier to all but the first code. (If your carrier prefers modifiers –RT and –LT, you probably must attach a modifier to the first code also.)

- Place add-on codes immediately following the base code identified in CPT. Do not attach a modifier to the add-on code, and do not reduce the fee. Add-on codes are identified in CPT by a plus sign (+) to the left of the procedure code with a note indicating which is the base code.

- Use the bilateral modifier (modifier –50) when the same procedure is performed on each breast. Remember to increase your fee above what it normally is for a unilateral procedure.

- Remember the Correct Coding Initiative (CCI) for Medicare and similar payor programs. The most common edit in breast surgery is for a biopsy of one lesion and an excision of another lesion on the same day. Use the distinct procedural service modifier (modifier –59). If the payor requires it, use the multiple procedure modifier (modifier –51) also.

Diagnostic coding

When reporting a diagnosis on a claim for a breast biopsy, report what is known at the time the claim is prepared, using ICD-9-CM code. If the claim is prepared before the pathology report has arrived, the only way to bill is to supply a nondefinitive diagnosis such as code 611.72, *Lump or mass in breast*. On the other hand, if the pathological report is complete, the diagnosis from the report for the biopsy may be used. If an additional procedure is needed (for example, re-excision to obtain satisfactory margins, mastectomy), use the definitive diagnosis from the first pathological report. Some cases involve two different diagnoses and it is important to associate the correct diagnosis and procedure codes.

The index to diseases in ICD-9-CM has a very large table containing codes for each anatomic site for each of six neoplasms: primary malignant, secondary malignant, cancer in situ, benign, uncertain behavior, and unspecified nature. There are also codes in the V10 series for personal history of malignant neoplasm. The V10 series should not be reported as a primary diagnosis. Rather, the full four- or five-digit ICD-9-CM code should be reported.

Conclusion

As we said earlier, coding for breast disease is complex because of the many ways care can progress. However, by following the rules for the diagnostic and procedural coding systems, it is possible to report all of the care provided, whether it involves multiple procedures done on the same day, care within the global period of another procedure, or any number of other seemingly perplexing scenarios. That allows us to give care when it is needed—something we all want to do.

Nonetheless, payment will not necessarily be made for all of the care surgeons render. Far too many payors either do not accept or do not recognize modifiers at this time, crippling their ability to accurately learn what happened during an episode of care. Although the Health Insurance Portability and Accountability Act (HIPAA) has imposed significant burdens on surgeons, perhaps it will encourage payors to accept modifiers.

By October 16, most payors must be compliant with the electronic transaction and code set provisions of HIPAA. (Small payors—those with fewer than 50 employees—have an additional year to become compliant.) The code set standard adopted for CPT says insurers must accept modifiers, although it goes on to say they do not have to make payment adjustments because of the presence of modifiers. Nevertheless, that is an important first step. The groundwork has been laid for local surgeons to explain to individual payors why they should recognize modifiers and make a payment differential for them. □