

# Sentinel lymph node mapping and its relation to biopsy

by Linda Barney, MD, FACS; Mark Savarise, MD, FACS; and Eric Whitacre, MD, FACS

Sentinel lymph node (SLN) analysis has become the standard of care for initial regional lymph node assessment of breast malignancies and melanoma, replacing complete regional lymph node dissection for most patients. Although Current Procedural Terminology (CPT)\* codes 38500–38780 serve to identify lymph node biopsy, complete regional dissection procedures, and formal lymphadenectomy procedures, these codes were developed before the widespread acceptance of SLN mapping.

Surgeons now have a code for accurate reporting of sentinel node mapping and identification. New add-on CPT code 38900, *Intraoperative identification (eg, mapping) of sentinel lymph node(s), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)*, is reported in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745. Approval of this add-on code marked the first opportunity for surgeons to capture the important work of identifying and mapping sentinel nodes as an integral part of SLN targeting for diagnostic sampling. Because of the complexity associated with breast cancer treatment options, a single stand-alone code insufficiently addressed the wide spectrum of uses for SLN mapping and biopsy.

When performing SLN mapping in the operating room, it is the surgeon who commonly injects the vital blue dye. This procedure is considered inherent in the mapping code, although radioactive tracer injection has a much wider spectrum of applications and clinician uses. Tracer may be injected remote from the immediate operating room and surgical procedure. CPT code 38792, *Injection procedure for identification of sentinel node*, is reported to identify the work associated with the injection of radioactive tracer and is separately reportable, when performed.

The following scenarios address the appropriate use

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of the various codes now available to capture the work component of SLN mapping and biopsy.

**A 55-year-old female recently diagnosed with cancer of the right breast undergoes right deep axillary SLN biopsy at the time of her partial mastectomy.**

The reportable procedures in this case are as follows:

19301, *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)*

38525–51, *Biopsy or excision of lymph node(s); open, deep axillary node(s)*

+38900, *Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of nonradioactive dye, when performed (List separately in addition to code for primary procedure)*

Partial mastectomy for excision of the tumor is reported with CPT code 19301. The removal of the deep axillary SLNs is reported with CPT code 38525, based on the depth of the node excised. Level I nodes can be deep or superficial depending on depth, patient habitus, and the extent of required dissection. According to CPT, Level II and III nodes are considered deep nodes, appropriate for the use of code 38525. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. This code accounts for the work of blue dye injection, use of the handheld gamma probe, and the dissection of the axilla to identify the sentinel nodes.

If the surgeon injects a radioactive tracer, report 38792. It may also be appropriate to append modifier 51 to account for the multiple procedures performed.

**A 55-year-old female recently diagnosed with cancer of the right breast undergoes right deep axillary SLN biopsy followed by a completion axillary dissection at the time of her partial mastectomy.**

The reportable procedures in this case are as follows:

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19302, *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy*

+38900, *Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)*

Partial mastectomy with axillary dissection is reported with CPT code 19302. Biopsy or excision of lymph node(s) is an inherent part of CPT code 19302. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900.

The National Correct Coding Initiative<sup>†</sup> edits prohibit the use of any axillary SLN biopsy code (38500 or 38525) as an inherent part of the more complex operation of ipsilateral axillary dissection. SLN mapping and injection of radioactive dye are distinct and separately reportable services not routinely included in 19302. If SLN biopsies of ipsilateral internal mammary nodes (38530) or contralateral axillary nodes (38500 or 38525) are performed at the same operative setting, both the sentinel node and axillary dissection codes are separately reportable.

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**A 68-year-old female recently diagnosed with cancer of both breasts undergoes bilateral superficial axillary SLN biopsy at the time of her bilateral total mastectomy.**

The reportable procedures in this case are as follows:

19303–50, *Mastectomy, simple, complete*

38500–50–51, *Biopsy or excision of lymph node(s); open, superficial*

+38900–50, *Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)*

Total mastectomy is reported with CPT code 19303. The biopsy of the superficial axillary SLNs is reported with CPT codes 38500, based on the depth of the node excised. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. Modifier 50 is added to all

of the codes because all of the procedures were done bilaterally.

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**A 68-year-old female recently diagnosed with cancer of the breast undergoes unilateral superficial axillary SLN biopsy and completion axillary dissection at the time of her total mastectomy.**

The reportable procedures in this case are as follows:

19307, *Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle*

38900, *Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)*

A modified radical mastectomy (total mastectomy with axillary dissection) is reported with CPT code 19307. CPT codes 38500 and 38505 are not separately reportable as the biopsy and excision of lymph node(s) is an inherent part of code 19307. Add-on code 38900 is separately reportable and appropriate to describe the work of sentinel node identification.

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**A morbidly obese 60-year-old female with locally advanced unilateral breast cancer is referred for SLN biopsy before undergoing neoadjuvant chemotherapy.**

The reportable procedures in this case are as follows:

38525, *Biopsy or excision of lymph node(s); open, deep axillary node(s)*

+38900, *Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)*

To report the removal of the deep axillary SLNs, use code 38525. To report the work associated with the intraoperative identification of the sentinel node, report add-on code 38900. A lumpectomy or mastectomy was not performed at this time and is not reportable. In this case, code 38740 is inappropriate for sentinel node biopsy; this code is for a complete axillary lymphadenectomy and requires removal of all superficial axillary adipose tissue and all lymph nodes contained in this tissue.

If a port is placed at the time of the aforementioned

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<sup>†</sup>All specific references to *National Correct Coding Initiative Coding Policy Manual for Medicare Services* are © 2011 Centers for Medicare & Medicaid Services. All rights reserved.

procedure for chemotherapy, report code 36561, *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older*. It also may be appropriate to append modifier 51 to account for the multiple procedures performed.

**A 52-year-old female undergoes a left partial mastectomy with SLN mapping and biopsy. Her intraoperative node analysis is negative, but the final pathology report reveals two lymph nodes are positive for cancer. She also has a positive inferior margin on her lumpectomy specimen.**

The reportable procedures in this case are as follows:

19302-58, *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy*

A staged procedure within the global postoperative period is reported with modifier 58. This modifier indicates that the procedure was planned or anticipated at the time of the first procedure, rather than an unexpected procedure or a complication.

A partial mastectomy (19301), excision of deep axillary lymph node(s) (38525), and SLN mapping (38900) are performed. Two days later, the final pathology report reveals two lymph nodes are positive for cancer and a positive inferior margin on the lumpectomy specimen. Report the re-excision of a previous lumpectomy with axillary dissection with code 19302-58.

A completion simple mastectomy after lumpectomy would be coded 19303-58, *Mastectomy, simple, complete*.

A completion axillary dissection alone would be coded either 38740-58, *Axillary lymphadenectomy; superficial*, or 38745-58, *Axillary lymphadenectomy; complete*, depending on the extent of dissection.

Superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue. 38745 is used to imply a more complete deep axillary dissection, which infers an axillary clearance of intervening fat and nodes from levels I-III.

**The surgeon performs his/her own injection of radioactive tracer before any sentinel node biopsy.**

Under these circumstances, the reportable procedure is 38792, *Injection procedure; for identification of sentinel node*.

The injection of radioactive tracer is excluded from the sentinel node identification code (38900) because it is frequently done by another health care professional.

*continued on page 59*

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clinical stage I and II breast cancer. These publications provide data demonstrating that examination of SLNs with IHC, as in the case described earlier in this article, is unnecessary. Recommendations regarding postoperative adjuvant therapy can be made based on primary tumor characteristics and routine H+E evaluation of SLNs. Physicians are encouraged to read these publications and decide whether to order IHC evaluation of breast cancer SLNs.

Both of these trials were supported by the National Cancer Institute (NCI). The authors also acknowledged the hundreds of surgeon investigators who participated in these trials. It is well known that NCI capitation payments do not cover the costs of these trials and that there was significant pro bono contribution by participating surgeons to answer the important question of occult nodal metastases in breast cancer. Patients and the com-

munity at large are grateful for those who supported these two important trials.

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**Dr. Ota**, of Durham NC, and **Dr. Nelson**, of Rochester, MN, are ACOSOG Co-Chairs.

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## Oweida Scholarship availability announced

The Board of Governors of the American College of Surgeons is pleased to announce the availability of the 2012 Nizar N. Oweida Scholarship. The Oweida Scholarship, an annual award administered by the Executive Committee of the Board of Governors, was established in 1998 in memory of Dr. Oweida, a general surgeon who practiced in a small town in western Pennsylvania.

The purpose of the Oweida Scholarship is to enable young surgeons practicing in small communities or rural areas to attend the Clinical Congress and benefit from the educational experiences it provides. The

\$5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees.

Applications consist of a curriculum vitae, plus a one-page essay discussing why the applicant characterizes his or her practice as serving a small community and why he or she would like to receive the scholarship.

The deadline for receipt of application materials is December 15, 2011. For the complete requirements for this scholarship, visit <http://www.facs.org/memberservices/oweida.html>, or contact Kate Early, Scholarships Administrator, at [kearly@facs.org](mailto:kearly@facs.org).

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## SOCIOECONOMIC TIPS, from page 32

### A 50-year-old male has a biopsy-proven 1.5 mm deep melanoma.

For melanoma patients, the SLN mapping and identification code 38900 can also be used and should be paired with the relevant node basins sampled. Excision of cervical nodes (codes 38510, *superficial* and 38520, *deep*), internal mammary nodes code 38530, and deep jugular nodes code 38542 are specifically described. Due to the fact that deep and superficial inguinal biopsies are not specifically described, 38500 can be used for a superficial biopsy because other regions, such as the inguinal, do not have specific codes for lymph node excision as opposed to full dis-

section. It also may be appropriate to append modifier 51 (multiple procedure), if the excision and sentinel node biopsy are done in the same setting or if more than one node basin is sampled. Modifier 51 is left off of code 38900 because it is an add-on code.

Use of SLN sampling may be advancing beyond the more common breast cancer and melanoma indications. As always, when a correct coding solution is not evident, the best alternative is to use the appropriate section unlisted code.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 8:00 am and 5:00 pm MST, excluding holidays. [Q]