Coding Brief: Coding for Breast Surgery

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Coding for surgical services can be complicated due to the numerous rules, guidelines, and exceptions. As a result, we often receive questions from users of the CPT® code set about coding, particularly for breast surgery. This coding brief provides answers to some frequently asked coding questions related to breast cancer operations; sentinel node biopsy; ultrasound-guided core biopsies; excision with wires; intraoperative assessment of margins; and more.

Question: Why are there two separate codes to report breast cancer operations with sentinel node biopsy and one unified code for mastectomy or lumpectomy with axillary node dissection?

Answer: The Current Procedural Terminology (CPT) codes for breast surgery were developed when axillary dissection was standard therapy for breast cancer. Modified radical mastectomy is reported with code 19307, while lumpectomy with axillary dissection is reported with code 19302. When coding for sentinel lymph node biopsy was developed, the code needed to apply to both breast and melanoma procedures. 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 an add-on code to be used with any lymph node biopsy or lymphadenectomy code to indicate the intraoperative work done to identify the sentinel lymph node(s). Therefore, when lumpectomy with sentinel node biopsy is performed, this is reported using codes 19301, 38525-51, and 38900. Code 38525 is reported for the biopsy of the node(s). When total mastectomy with sentinel node biopsy is performed, codes 19303, 38525 with modifier 51 (reported for the biopsy of the lymph nodes), and add-on code 38900 are reported.

Question: When a total mastectomy with sentinel node biopsy is performed, I obtain a frozen section of the nodes and proceed to dissect the axilla if the nodes are positive. Can I report the axillary node biopsy separately?

Answer: No. This would be reported with the code for the modified radical mastectomy (19307) and add-on 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), would be reported for the sentinel node mapping

procedure. It would not be appropriate to report the axillary node biopsy separately from the axillary dissection.

Question: Can I code for injection of radioactive tracer and blue dye for sentinel lymph node biopsy?

Answer: If you inject radioactive tracer preoperatively, report code 38792. Injection of blue dye, when performed, is included in the sentinel node code, 38900.

Question: I perform ultrasound-guided core biopsies but do not leave localization devices in the biopsy location. Should I use codes 19083 and 19084?

Answer: Yes. All of the image-guided biopsy codes, 19081-19086, specify that the biopsy is inclusive of the placement of breast localization devices, including clips and metallic pellets, when performed, and imaging of the biopsy specimen, when performed. In other words, clip placement or specimen imaging cannot be reported separately, but the image-guided biopsy code is appropriate for the biopsy regardless if clip placement or specimen imaging is performed.

Question: Do you code differently for excision with multiple wires for localization than excision with one wire?

Answer: No. The new image-guided localization codes are per lesion, not per wire. Thus, multiple wires may be placed to identify any lesion, however, this would be reported the same as for placing a single wire. An excision through a single incision may only be reported once, regardless of the number of wires used for the localization.

Question: How do you code for excision of additional tissue for margins at the time of lumpectomy? Is there a code for the added work of orienting and inking margins?

Answer: CPT codes 19120 and 19125 are used for excision of breast lesions in which attention to surgical margins and assurance of complete tumor resection is unnecessary. For oncologic resection with attention to margins (lumpectomy or partial mastectomy), code 19301 describes the procedure in which margin status is indicated by any method, which may include excision of additional surrounding tissue for margins. As a corollary, code 19301 is reported whether the breast cancer is palpable or removed with preoperative placement of a localization wire.

Question: How do you code re-excision of a lumpectomy cavity when you must return for positive margins on final pathology a week after a lumpectomy?

Answer: Use code 19301 for lumpectomy with modifier 58, Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period, appended. Indicate in the operative report that this procedure is a planned return to the operating room for more extensive work.

Question: How should I code for nipple-sparing mastectomy and skin-sparing mastectomy to distinguish them from total mastectomy?

Answer: All of these procedures are classified mastectomy for cancer and should all be reported with code 19303. No special distinctions are made for the type of incision. The operative report should use state 'total nipple-sparing' or 'total skin-sparing' mastectomy to avoid confusion with a subcutaneous mastectomy.

Question: How do you code for ablation of breast lesions with cryotherapy, microwave, radiofrequency ablation (RFA), or laser?

Answer: The Food and Drug Administration (FDA) has not specifically approved cryotherapy, microwave, RFA, or laser devices for ablative treatment of breast cancer. There are no specific codes for these types of procedures and, therefore, they would be reported with code 19499, Unlisted procedure breast. When reporting an unlisted code to describe a procedure or service, it will be necessary to submit supporting documentation (eg, a procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

