Mastectomy Procedures

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The December 2019 issue of CPT Assistant included an article, Breast and Chest Wall Procedures, that highlighted specific procedures in the Integumentary System section that were renumbered and relocated to the Musculoskeletal System section in the CPT 2020 code set. This article focuses on the new introductory guidelines added to the Integumentary System/Mastectomy Procedures subsection of the CPT 2020 code set.

New Guidelines

The Mastectomy Procedures subsection includes mastectomy codes reported for gynecomastia (19300) and the treatment or prevention of breast cancer codes (19301-19307) reported for the removal of breast tissue for breast-size reduction to treat gynecomastia in males (see Figure 1) and not for the treatment or prevention of breast cancer. Code 19301 describes a partial mastectomy in which only a portion of the ipsilateral breast tissue is removed along with a wide local excision of surrounding tissue (eg, lumpectomy, tylectomy, quadrantectomy, or segmentectomy). Code 19302 is reported when a complete axillary lymphadenectomy is performed with a partial mastectomy. Code 19303 describes total removal of ipsilateral breast tissue with or without removal of skin and/or nipple (eg, nipple-sparing). Note that code 19303 does not include excision of pectoral muscle(s) and/or axillary and internal mammary lymph nodes. Codes 19305-19307 describe radical mastectomy procedures (total removal of the ipsilateral breast tissue) that variously include excision of pectoral muscle(s), and/or axillary lymph nodes, and/or internal mammary lymph nodes.

Coding Tip

To report bilateral procedures for codes 19300-19303 and 19305-19307, append modifier 50 to the procedure code.

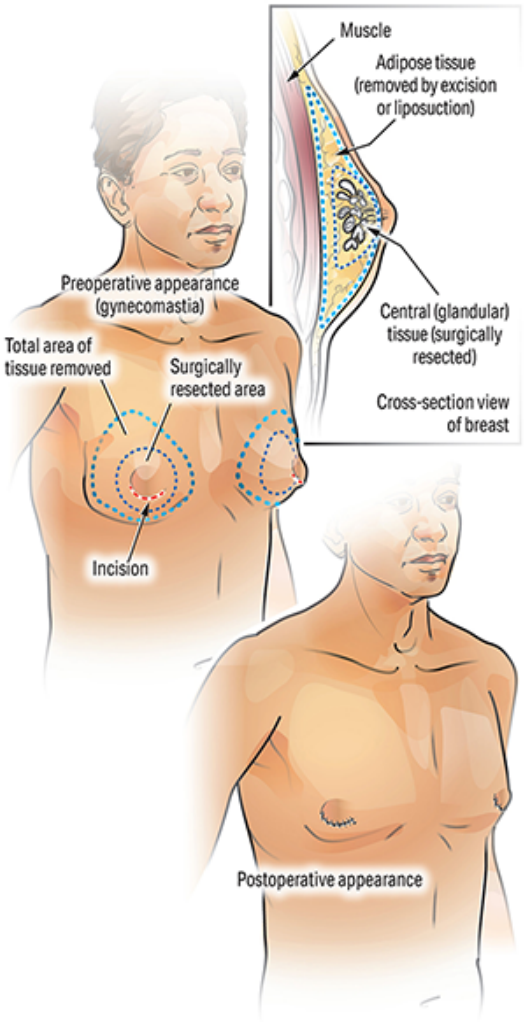
Mastectomy Procedures

19300
Mastectomy for gynecomastia

(For breast tissue removed for breast-size reduction for other than gynecomastia, use 19318)

19301
Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302
with axillary lymphadenectomy

(For placement of radiotherapy afterloading balloon/brachytherapy catheters, see 19296-19298)



(Intraoperative placement of clip[s] is not separately reported)

(For the preparation of tumor cavity with placement of an intraoperative radiation therapy applicator concurrent with partial mastectomy, use 19294)

(For radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report, use 0546T)

19303
Mastectomy, simple, complete

(Intraoperative placement of clip[s] is not separately reported)

(For immediate or delayed insertion of implant, see 19340, 19342)

(For gynecomastia, use 19300)

(19304 has been deleted)

(For breast tissue removed for breast-size reduction for gynecomastia, use 19300)

(For breast tissue removed for breast-size reduction for other than gynecomastia, use 19318)

19305
Mastectomy, radical, including pectoral muscles, axillary lymph nodes

(Intraoperative placement of clip[s] is not separately reported)

(For immediate or delayed insertion of implant, see 19340, 19342)

19306
Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)

(Intraoperative placement of clip[s] is not separately reported)

(For immediate or delayed insertion of implant, see 19340, 19342)

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

(Intraoperative placement of clip[s] is not separately reported)

(For immediate or delayed insertion of implant, see 19340, 19342)

Summary of Changes

The following is a summary of the changes in the Integumentary and the Musculoskeletal sections.

- New introductory guidelines were created to differentiate the mastectomy procedures and to provide guidance for accurate reporting.
- New and updated instructional parenthetical notes were added throughout the Mastectomy Procedures subsection in the Integumentary section and the Musculoskeletal System section to reflect additional parenthetical notes to codes and to clarify instructions in the guidelines.
- Code 19304, Mastectomy, subcutaneous, a technique introduced in the 1960s but is no longer the standard of care, was deleted.

The following clinical examples and procedural descriptions reflect typical clinical scenarios for which the codes with new parenthetical notes would be reported appropriately.

Clinical Example (19300)

A 66-year-old female undergoes stereotactic needle biopsy of an area of non-palpable suspicious microcalcifications in the breast showing duct carcinoma in situ. Review of mammogram shows suspicious area is confined to a single quadrant of the breast and is amenable to wide local excision with planned postoperative radiation therapy.

Description of Procedure (19300)

Make incision to obtain optimal cosmetic result and still permit efficient removal of previous needle biopsy site and residual calcifications, which have been localized preoperatively using a needle-wire localization device. If patient is under standby anesthesia, administer local anesthesia at the operative site as needed throughout procedure to alleviate discomfort. Sharply divide skin and subcutaneous tissues. Secure hemostasis with fine sutures, ligatures, and/or electrocautery. Use sharp dissection to divide breast parenchyma surrounding the area indicated by needle localization wire(s). Throughout this dissection, refer to the localization radiographs that are sent with the patient from the radiology suite to ensure appropriate margins around the localized target while minimizing the total volume of breast tissue to be removed. During this process, pay close attention to the deep margin, as any suspicious findings may require resection of superficial muscle fibers to achieve a definitive final pathologic margin. Carefully monitor relationship of the lumpectomy

cavity to the skin, as thin flaps may require excision or revision to prepare the lumpectomy site for possible subsequent insertion of a partial breast brachytherapy catheter. Carefully examine specimen to ensure there are no clinically suspicious areas at the surgical margins, and mark using sutures and/or ink to orient the specimen for the pathologist. X-ray specimen and review with radiologist to ensure complete removal of targeted lesion. Excise additional margins from the lumpectomy cavity as indicated based on examination of specimen, specimen radiograph, or preliminary examination of specimen by pathologist. Carefully examine lumpectomy cavity and additional margins excised to ensure complete removal of all potentially suspicious areas noted intraoperatively. Examine operative site for meticulous hemostasis and irrigate copiously with antibiotic solution. Place small clips at the periphery of the lumpectomy cavity for future radiographic identification. Conduct an instrument, needle, sponge, and lap-pad count. Place subcutaneous sutures where appropriate. Re-approximate skin edges using interrupted and running subcuticular suture.

Clinical Example (19302)

A 53-year-old female has previously undergone ultrasound guided needle biopsy of a nonpalpable 2 cm mass in the breast showing infiltrating ductal carcinoma and biopsy of an axillary lymph node showing metastatic carcinoma. There is no evidence of other local or distant disease. The patient is a candidate for partial mastectomy and axillary node dissection.

Description of Procedure (19302)

A skin incision is made to obtain the optimal cosmetic result and still permit efficient removal of the previous needle biopsy site and residual calcifications, which have been localized preoperatively using a needle-wire localization device. If the patient is under standby anesthesia, local anesthesia is administered at the operative site as needed throughout the procedure to alleviate discomfort. The skin and subcutaneous tissues are sharply divided. Hemostasis is secured with fine sutures, ligatures and/or the electrocautery. Sharp dissection is used to divide the breast parenchyma surrounding the area indicated by the needle localization wire(s). Throughout this dissection, reference is made to the localization ultrasound, sent with the patient from the radiology suite to ensure appropriate margins around the localized target while minimizing the total volume of breast tissue to be removed.

During this process, close attention is paid to the deep margin, as any suspicious findings may require resection of superficial muscle fibers to achieve a definitive final pathologic margin. Relationship of the lumpectomy cavity to the skin is also carefully monitored, as thin flaps may require excision or revision to prepare the lumpectomy site for possible subsequent insertion of a partial breast brachytherapy catheter. The specimen is carefully examined to ensure there are no clinically suspicious areas at the surgical margins and is marked using sutures and/or ink to orient the specimen for the pathologist. The specimen x-ray is reviewed with the radiologist to ensure complete removal of the targeted lesion. Additional margins from the lumpectomy cavity are excised as indicated based on examination of the specimen or the specimen radiograph or based on the preliminary examination of the specimen by the pathologist. The lumpectomy cavity is also carefully examined and additional margins excised to ensure complete removal of all potentially suspicious areas noted intraoperatively.

Attention is then directed to the axilla where a skin incision is made exposing the clavipectoral fascia. This is incised and the axillary contents exposed. The limits of the axilla (to include all of level I and II) are defined up to the inferior border of the axillary vein. Using a combination of blunt and sharp dissection, the level I and II axillary contents are dissected

from surrounding structures, taking care to identify and avoid injury to the long thoracic nerve, the thoracodorsal neurovascular bundle, the intercostobrachial nerve and the medial pectoral nerve. Hemostasis is obtained with ligatures, placement of small clips, or using the electrocautery. The exposed axilla is carefully examined to ensure all clinically suspicious lymph nodes have been removed. A drain is inserted and secured with sutures.

Both operative sites are examined for meticulous hemostasis and irrigated copiously with antibiotic solution. Small clips are placed at the periphery of the lumpectomy cavity for future radiographic identification. An instrument, needle, sponge, and lap-pad count is conducted. Subcutaneous sutures are placed where appropriate. The skin edges are reapproximated using interrupted and running subcuticular suture.

Clinical Example (19303)

A 68-year-old female undergoes stereotactic needle biopsy of an area of suspicious microcalcifications in the left breast that shows ductal carcinoma in situ. Review of mammogram shows the area biopsied is part of an extensive area of suspicious calcifications extending over a 7-cm area along a ductal distribution. Following review of surgical alternatives with the patient and after considering patient's breast size relative to the extent of calcifications, a mastectomy is planned.

Description of Procedure (19303)

An incision encompassing the nipple areolar complex and, if possible, the previous biopsy site is made. This may be performed based on previous markings to achieve optimal cosmetic or reconstructive results. The skin and subcutaneous tissues are sharply divided. Hemostasis is secured with fine sutures, ligatures, and/or electrocautery. Sharp dissection is used to create skin flaps. Throughout this dissection, close attention is paid to thickness of the flaps as well as viability of the flaps. Dissection is carried out to the level of the superficial mammary fascia to the limits of the clavicle, lateral border of the sternum, insertion of the rectus fascia, and latissimus dorsi tendon. The breast is dissected from underlying pectoralis major muscle fibers, including the deep fascia in continuity with the specimen. During this process, close attention is paid to inspection of the deep margin, as any suspicious findings may require resection of superficial muscle fibers to achieve a definitive final pathologic margin. The clavipectoral fascia is incised to expose the axilla, which is examined for suspicious adenopathy. Meticulous attention is paid to identifying and preserving the thoracodorsal and long thoracic nerves, as injury to these can result in permanent debilitating deformity. The breast is dissected from its remaining attachments along the serratus anterior fascia. The specimen is carefully marked using sutures and/or other labeling techniques to definitively orient the specimen for the pathologist. The operative site is examined for meticulous hemostasis and irrigated copiously with antibiotic solution. A drain is inserted through a separate stab incision in the inferior skin flap and secured to the skin. An instrument, needle, sponge, and lap-pad count is conducted. Subcutaneous sutures are placed where appropriate to eliminate dead space. Flaps are reinspected for viability, and any areas are trimmed, as necessary. Skin edges are reapproximated using interrupted and running subcuticular suture.

