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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Rules To Follow To Make The Best Of Breast Procedures

'Lumpectomy' is a general term, so proceed with caution when choosing excision, mastectomy codes

During breast procedures, if the surgeon removes a lesion along with a significant portion of surrounding tissue, you should choose a partial mastectomy code. But you'll need a coding makeover if the surgeon removes only the lesion and a small portion of surrounding tissue.

Here are four rules that can help guide you through this difficult decision process:

Rule 1: Consider Intent To Obtain Margins

As a general guideline, if the surgeon removes a breast lesion along with a margin of healthy tissue, you can choose the partial mastectomy code (19160, Mastectomy, partial [e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy]) to describe the procedure. In this case, the surgeon usually assumes that the mass is malignant.

Don't get hung up on measurements: There is no specific requirement in CPT or CMS regulations that says the margin must be of a specific size (for instance, 1 cm or more) to qualify as a partial mastectomy. Rather, the margins must only be "adequate" to ensure that the surgeon removes possible malignant tissue surrounding the excised mass.

"Despite a surgeon's best effort to clear a lesion with margins, he may not get 1 cm but still could have performed a segmental mastectomy," says **Donald Keenan**, **MD, PhD,** assistant professor of surgery at the **University of Pittsburgh School of Medicine** and attending breast surgeon for the Magee-UPCI Breast Program.

Documentation matters: "This is the case where you are going to have to have some physician education," says **Kim Garner, CPC, CCS-P, CHCC**. "The doctors are going to have to start putting in their operative report that they paid special attention to the surgical margins." Without documentation of margin removal, you cannot claim 19160.

Minimal Margins Call For 19120

If the surgeon removes only the tumor and no or very little margin, the excision 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 most appropriate. In such a case, the lump is likely fairly small and clearly defined, and the surgeon assumes the tumor is not malignant.

"If I have histological confirmation that a lesion is benign, then I excise the lesion, taking minimal, if any, surrounding breast tissue," Keenan says.

Watch for "staged" procedures: If the surgeon removes only the lesion with minimal margins (19120), but the pathology report reveals malignancy, the surgeon must return the patient to the operating room and remove additional tissue, says South Carolina general surgeon **M. Trayser Dunaway, MD**. In such a case, you may report the follow-up procedure using the partial mastectomy code (19160) with modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) appended.

Remember: Because the results of the first excision led to the decision to perform the partial mastectomy, you should report both procedures separately, according to CMS guidelines outlined in the National Correct Coding Initiative and elsewhere.

Rule 2: 25 Percent Ensures 19160

The term "quadrantectomy" (which means removal of one quarter of the breast tissue) in 19160's definition means that you can safely choose 19160 instead of 19120 if the surgeon removes at least a quarter of the breast tissue, Garner says.

Note, however, that CPT does not explicitly define when a simple excision "crosses the line" to become a partial mastectomy. In other words, removing 25 percent of the breast tissue definitely qualifies as a partial mastectomy, but CPT does not prohibit reporting 19160 for removal of 20 percent of the breast tissue, for instance - as long as the surgeon takes adequate margins when removing the breast mass.

"I don't think that you can code based on volume," Keenan says. "It's more of a strategy. A surgeon under these conditions has to be aware of the location of the cancer and take enough tissue to get good margins." If the surgeon's intent during surgery was to remove a lesion with margins, you should choose 19160.

Rule 3: Watch For Node Excision

Often, with partial mastectomy, the surgeon will perform an axillary lymphadenectomy to remove the lymph nodes between the pectoralis major and the pectoralis minor muscles. The surgeon may also remove the nodes in the axilla through a separate incision at the same time.

In such cases, you should report 19162 (Mastectomy, partial [e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy]; with axillary lymphadenectomy) for the combined procedure rather than reporting 19160 and 38745 (Axillary lymphadenectomy; complete) separately.

Beware "staged" exception: Following some partial mastectomies (19160), the surgeon may return during the postoperative period to see if there has been any lymph node involvement and, if so, may choose to remove the nodes at that time. In such a case, you would report the lymphadenectomy as a staged procedure using 38745 with modifier 58 appended.

Rule 4: Decipher 'Lumpectomy'

You shouldn't base your code choice on the term "lumpectomy" in the surgeon's documentation. Technically, lumpectomy describes excision of a small, intact tumor, whether cancerous, precancerous or fibroid - but physicians often use the term to describe any excision of breast tissue, regardless of size.

Although "lumpectomy" does appear in the 19160 descriptor, the term is used so widely that - depending on exactly what the surgeon did - either 19120 or 19160 could apply, says **Jan Rasmussen, CPC**, a general surgery coding consultant in Eau Claire, WI.

The CPT descriptor for 19160 also includes the terms "tylectomy" and "segmentectomy," but "these terms only serve to confuse," Dunaway says. "Tylectomy and segmentectomy can technically be identical or each one different. The definitions are subjective."

Best advice: Both Rasmussen and Dunaway agree: You are much better off choosing a code based on the surgeon's effort to obtain margins around the excised mass rather than according to the terminology the surgeon uses to describe the procedure.