

## Percutaneous Image-Guided Breast Biopsy (NCD 220.13)

<b>Policy Number</b>	220.13	<b>Approved By</b>	UnitedHealthcare Medicare Reimbursement Policy Committee	<b>Current Approval Date</b>	03/12/2014
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### IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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### Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

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The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

### Summary

#### Overview

Percutaneous image-guided breast biopsy is a method of obtaining a breast biopsy through a percutaneous incision by employing image guidance systems. Image guidance systems may be either ultrasound or stereotactic.

The Breast Imaging Reporting and Data System (or BIRADS system) employed by the American College of Radiology provides a standardized lexicon with which radiologists may report their interpretation of a mammogram. The BIRADS grading of mammograms is as follows: Grade I-Negative, Grade II-Benign finding, Grade III-Probably benign, Grade IV-Suspicious abnormality, and Grade V-Highly suggestive of malignant neoplasm.

#### Reimbursement Guidelines

##### Nonpalpable Breast Lesions

Effective January 1, 2003, Medicare covers percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for a radiographic abnormality that is nonpalpable and is graded as a BIRADS III, IV, or V.

##### Palpable Breast Lesions

Effective January 1, 2003, Medicare covers percutaneous image guided breast biopsy using stereotactic or ultrasound imaging for palpable lesions that are difficult to biopsy using palpation alone. Contractors have the discretion to decide what types of palpable lesions are difficult to biopsy using palpation.

### CPT/HCPCS Codes

Code	Description
10022	Fine needle aspiration; with imaging guidance
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance (effective 1/1/2014)
19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) (effective 1/1/2014)
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance (effective 1/1/2014)
19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure) (effective 1/1/2014)

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19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance (effective 1/1/2014)
19086	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) (effective 1/1/2014)
19102	Biopsy of breast; percutaneous, needle core, using imaging guidance (expired 12/31/2013) (See 19081-19086 for replacement codes)
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (expired 12/31/2013) (See 19081-19086 for replacement codes)
19283	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance (effective 1/1/2014)
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (expired 12/31/2013) (See 19081-19086 for replacement codes)
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
77031	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation (expired 12/31/2013) (See 19081 and 19283 for replacement codes)

### References Included (but not limited to):

**CMS NCD**

NCD 220.13 Percutaneous Image-Guided Breast Biopsy

**CMS Benefit Policy Manual**

Chapter 15; § 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, § 260 Ambulatory Surgical Center Services

**CMS Claims Processing Manual**

Chapter 12; § 90.3 90.3 - Physicians' Services Performed in Ambulatory Surgical Centers (ASC)

Chapter 13; § 80.1 Physician Presence, § 80.2 Multiple Procedure Reduction

Chapter 14; § 10 General

**CMS Transmittals**

Transmittal 159, Change Request 2232, Dated 09/27/2002

Transmittal 2636, Change Request 7501, Dated 01/16/2013 (National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION)

Transmittal 1419, Change Request 5865, Dated 01/18/2008 (January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0)

**UnitedHealthcare Medicare Advantage Coverage Summaries**

Radiologic Diagnostic Procedures

**UnitedHealthcare Reimbursement Policies**

Ultrasound Diagnostic Procedures (NCD 220.5)

**UnitedHealthcare Medical Policies**

Omnibus Codes

**Others**

Program Memorandum Intermediaries/Carriers, Transmittal AB-02-128, Change Request 2232, Dated 09/27/2002 (Coverage and Billing for Percutaneous Image-Guided Breast Biopsy)

**Percutaneous Image-Guided Breast Biopsy (NCD 220.13)****History**

<b>Date</b>	<b>Revisions</b>
03/12/2014	Annual review
04/24/2013	Annual Review, no changes
04/24/2012	References reviewed with no changes taken to committee