

Medicare Reimbursement for Magnetic Resonance Guided Percutaneous Breast Biopsy Procedures¹

Magnetic resonance (MR) guidance during percutaneous breast biopsy procedures allows the physician to precisely calculate the position and depth of the needle placement in order to obtain a breast tissue sample of a suspicious lesion. Physicians may perform different types of percutaneous breast biopsy procedures depending on the size, type and extent of the breast lesion. Percutaneous breast biopsy procedures include fine needle aspiration, core needle breast biopsy and vacuum-assisted breast biopsy.²

This advisory addresses coding, coverage and payment for magnetic resonance (MR) guided percutaneous breast biopsy procedures (i.e., fine needle aspiration, core needle and vacuum-assisted biopsies)³ when performed in hospital inpatient, hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings.⁴ While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify medical procedures provided to Medicare patients.⁵ The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

January 2008

www.gehealthcare.com/reimbursement

In addition to CPT I codes, the Center for Medicare and Medicaid (CMS) maintains Healthcare Common Procedure Coding System (HCPCS) Level II codes which are used to describe and identify many items and services that are not included in the AMA's CPT coding system. HCPCS Level II codes are alphanumeric and are developed and maintained by CMS.

Currently, MR guidance, including the radiological supervision and interpretation associated with the guidance, is reported using the following code:

CPT 77021 – Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation



According to the AMA, it is appropriate to report CPT code 77021 when performed in conjunction with a percutaneous breast biopsy procedure.⁶ The percutaneous breast biopsy procedure would be reported with the appropriate code listed in Table 1 based on the type of procedure performed.

During a percutaneous breast biopsy procedure, the physician may elect to place a localization clip to identify the area of interest. The placing of a localization clip is reported as an “add-on” code to the primary percutaneous breast biopsy procedure. The code for the localization clip is as follows:

CPT 19295 – Image guided placement, metallic localization clip, percutaneous, during breast biopsy

Effective January 1, 2008, CMS issued the following new HCPCS code to be reported if a paramagnetic imaging agent is used in conjunction with MR guidance.⁷ Please note that the FDA has not approved any gadolinium-based magnetic resonance agent for the indication of MR guided percutaneous breast biopsy procedures.

HCPCS A9579 – Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml.

In addition to the codes for the MR guidance and percutaneous breast biopsy procedure, there may be additional codes reported for the related supplies and services associated with the procedure. Because the supplies and services could vary substantially based upon the procedure performed for each patient, these codes have not been addressed within this customer advisory.

When submitting claims to Medicare, procedural CPT codes are reported with diagnosis codes describing the patient’s documented medical conditions. These diagnoses are reported using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

The preceding coding guidance has been provided by authoritative sources; however, individual circumstances can be an important factor in appropriate coding for imaging procedures. It is the provider’s responsibility to consult with an authoritative coding resource to determine and submit appropriate codes. The existence of a code does not necessarily mean the procedure is covered and payable.

Reimbursement

Medicare reimbursement for medical procedures is comprised of a **professional component**, the amount paid for the physician’s interpretation and report, and a **technical component**, the amount paid for all other services (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the **total or global reimbursement**.

Currently, Medicare reimburses medical procedures differently based on the site of care. In a **hospital inpatient** site of care, the technical (facility) payment is subsumed within the payment to the hospital that is determined based on the Diagnosis Related Group (DRG) to which the patient is assigned. In a **hospital outpatient department**, the technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC) under Medicare’s hospital outpatient prospective payment system (HOPPS). Effective January 1, 2008, reimbursement for guidance services procedures performed within the hospital outpatient department will be packaged into the payment for the primary procedure. In an **IDTF or physician office**, the technical component is reimbursed under the Medicare physician fee schedule. The professional component is reimbursed under the Medicare physician fee schedule, regardless of the setting.

Payment for Contrast

Medicare reimburses contrast agents differently based on the site of care. In the **hospital outpatient** department, reimbursement for contrast agents is packaged into the payment for the primary procedure. In the **IDTF and physician office setting**, Medicare reimburses providers an additional amount for the contrast, Gadolinium, based upon the average sales price (ASP) rate. The rate is adjusted quarterly using the previous quarter’s ASP data. Providers are required to report the code corresponding to this contrast, as well as respective dosage quantity, in order to receive separate reimbursement.⁸

Table 1 provides information concerning Medicare national payment amounts for MR guided breast biopsy procedures performed in the hospital inpatient, hospital outpatient, IDTF and physician office sites of care. For more information about reimbursement of MR guided percutaneous breast biopsy procedures in your area, consult your local Medicare contractor.

CPT/HCPCS Code	Reimbursement Component	Hospital Inpatient Departments ⁹	Hospital Outpatient Department ¹⁰	IDTF and Physician Office ^{11, 12, 13}
CPT 77021 Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation [For procedure, see appropriate organ or site]	Technical	Included in DRG	Packaged in APC	\$409.43
	Professional	\$73.13	\$73.13	\$73.13
	Total	DRG + \$73.13	APC + \$73.13	\$482.56
CPT 19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)	Technical	Included in DRG	Packaged in APC	Not Applicable
	Professional	\$95.22	\$95.22	Not Applicable
	Total	DRG + \$95.22	APC + \$95.22	\$95.22
CPT 10022 Fine needle aspiration; with imaging guidance [For radiological supervision and interpretation, see 76942, 77002, 77012, 77021]	Technical	Included in DRG	\$275.60	Not Applicable
	Professional	\$61.32	\$61.32	Not Applicable
	Total	DRG + \$61.32	\$336.92	\$135.21
CPT 19102 Biopsy of breast; percutaneous, needle core, using imaging guidance [For imaging guidance performed in conjunction with 19102, 19103, see 76942, 77012, 77021, 77031, 77032] [For placement of percutaneous localization clip, use 19295]	Technical	Included in DRG	\$453.16	Not Applicable
	Professional	\$97.88	\$97.88	Not Applicable
	Total	DRG + \$97.88	\$551.04	\$211.38
CPT 19103 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance [For imaging guidance performed in conjunction with 19102, 19103, see 76942, 77012, 77021, 77031, 77032] [For placement of percutaneous localization clip, use 19295]	Technical	Including in DRG	\$864.74	Not Applicable
	Professional	\$181.29	\$181.29	Not Applicable
	Total	DRG + \$181.29	\$1046.03	\$546.55
HCPCS A9579¹⁴ Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml	Technical	Included in DRG	Packaged	106% ASP

Table 1: 2008 Medicare Reimbursement for MR Guided Percutaneous Breast Biopsy Procedures (Reflects National Rates, Unadjusted for Locality)

Coverage

Medicare's National Coverage Determination (NCD), *Percutaneous Image-Guided Breast Biopsy*, indicates coverage for percutaneous image-guided breast biopsy procedures is limited to specific types of palpable and non-palpable breast lesions. Palpable lesions are defined as those lesions that are "difficult to biopsy using palpation alone." Non-palpable lesions are "radiographic abnormalities that are non-palpable and graded as a BIRADS III, IV, or V."¹⁵ The national coverage determination is described in the Internet-Only Manual (IOM) for Medicare National Coverage Determinations at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf (scroll to Section 220.13).

Additionally, the Center for Medicare and Medicaid (CMS) covers the use of MR guidance when performed in conjunction with percutaneous breast biopsy procedures using percutaneous needle core, automated vacuum assisted or rotating biopsy devices (i.e., CPT codes 19102 and 19103).¹⁶

According to the NCD, local Medicare contractors "have discretion to decide what types of palpable lesions are difficult to biopsy using palpation."¹⁷ Some local Medicare contractors have developed Local Coverage Determinations (LCDs) that address percutaneous image-guided breast biopsies. Importantly, these LCDs may provide for, restrict or deny coverage for this procedure based on a variety of factors such as the patient clinical indications or type of breast biopsy device. To confirm coverage, consult your local Medicare contractor for specific information on coverage. A directory of local Medicare contractors can be accessed at http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf. To access the LCDs, refer to <http://www.cms.gov/mcd/search.asp> or the individual contractor's website.

With respect to private payers, some may rely on Medicare reimbursement policies while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for MR guided breast biopsy procedures as well.

¹ Information presented in this document is current as of January 15, 2008. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

² Radiology Info™, MR-Guided Breast Biopsy. April 12, 2006. Copyright©2006 RSNA. Link: <http://www.radiologyinfo.org/en/pdf/breastbimr.pdf>

³ The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

⁴ The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients in those states. In addition, licensure, certificate of need, and other restrictions may be applicable.

⁵ CPT codes and descriptions only are copyright © 2007 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

⁶ American Medical Association. CPT® 2008 Professional Edition.

⁷ American Medical Association. HCPCS 2007 Medicare's National Level II Codes.

⁸ Federal Register, Vol. 71, No. 231, December 1, 2006, page 69665.

⁹ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is paid pursuant to the hospital inpatient prospective payment system. The professional component for imaging procedures performed in the hospital inpatient setting is generally paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these professional payment amounts are applicable through June 30, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

¹⁰ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 72, No. 227, November 27, 2007. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these professional payment amounts are applicable through June 30, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

¹¹ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Both the technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these technical and professional payment amounts are applicable through June 30, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

¹² Per the Deficit Reduction Act (DRA) of 2005, designated imaging services with a 2008 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2008 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 72, No. 227, November 27, 2007, will be capped at the 2008 HOPPS payment amount. Accordingly, the global payment amount is the sum of the professional payment amount and the DRA capped technical payment amount

¹³ CMS has identified services that can not be split into a professional component (PC) and technical component (TC); therefore, the MPFS payment is a global payment amount. [CMS Medicare Claims Manual, Chapter 23] Services designated as not having a PC and/or TC are identified by a PC/TC indicator in the National Physician Fee Schedule Relative Value File: Calendar Year 2008.

¹⁴ The majority of separately payable drugs in the IDTF and physician office settings are paid based upon the average sales price (ASP) rates adjusted quarterly using the previous quarter's ASP data. The Center for Medicare and Medicaid Services (CMS) ASP drug pricing file can be found at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage.

¹⁵ Medicare National Coverage Determination, Percutaneous Image-Guided Breast Biopsy (220.13). Effective date: January 1, 2003.

¹⁶ CMS transmittal, Coverage and Billing for Percutaneous Image-guided Breast Biopsy (AB-02-128), link: <http://www.cms.hhs.gov/Transmittals/downloads/AB02128.pdf>.

¹⁷ Medicare National Coverage Determination, Percutaneous Image-Guided Breast Biopsy (220.13). Effective date: January 1, 2003.

www.gehealthcare.com/reimbursement

GE Healthcare
3000 North Grandview
Waukesha, WI 53188
U.S.A.

www.gehealthcare.com



imagination at work

©2008 General Electric Company.
GE and GE Monogram are trademarks of General Electric Company.

General Electric Company, doing business as GE Healthcare.