Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Capture Each Step of 2-Phase Case to Boost Breast Surgery Pay

Distinguish lesion excision, lumpectomy.

When a patient advances through multiple diagnostic and treatment steps for breast cancer, your surgeon might perform several procedures -- and you might face bundling issues that limit your billing opportunities.

Let our experts lead you through one case in point - from initial patient complaint to definitive diagnosis -- so you can learn how to capture all the pay your surgeon deserves.

Phase 1: Needle Specimens for Diagnosis

Scenario: Based on mammogram findings of a lump in her right breast (upper inner quadrant), a patient presents to your surgeon's suite for an ordered fine needle aspiration (FNA). "Physicians often use FNA to obtain cellular specimens from a breast mass for diagnosis," says **Melanie Witt, RN, COBGC, MA**, an independent coding consultant in Guadalupita, N.M.

For the FNA procedure, the surgeon inserts a thin needle into the breast mass and uses the syringe to extract cells, which he sends to pathology for immediate evaluation for adequacy. Based on the report that the specimen is inadequate for diagnosis, the surgeon performs a second FNA of the same lesion, this time under radiologic guidance. The specimen again returns inadequate for diagnosis. The surgeon consults with the pathologist, who recommends a percutaneous needle core biopsy (PNB) of the lesion due to cellular artifacts.

The surgeon proceeds to perform a PNB of the lesion with imaging guidance, using a larger-bore needle to remove a "core" tissue sample from the lesion. The surgeon supervises and interprets the fluoroscopy performed by a radiologist for both the FNA and the PNB. The surgeon completes the procedure by placing a localization clip to mark the biopsy site.

Pitfall: Bundling rules might limit what you can bill, even though the op report identifies multiple distinct procedures that your surgeon performs, as follows:

- 10021 -- Fine needle aspiration; without imaging guidance
- 10022 -- ... with imaging guidance
- 19102 -- Biopsy of breast; percutaneous, needle core, using imaging guidance
- 77002 -- Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
- +19295 -- Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure).

Diagnosis: The pathology report returns a diagnosis of ductal carcinoma in situ (DCIS) from the needle core biopsy specimen.

Solution: You should code the surgeon's services for the entire encounter as 19102, 77002- 26 (Professional component) and +19295.

No FNA charge: You shouldn't bill for the surgeon's 10021 and 10022 services. "Although the surgical report documents procedures to procure lesion cells for diagnosis, you should report only the final procedure that results in a diagnostically viable specimen," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** manager of compliance education for the University of Washington Physicians Compliance

Program in Seattle. That means reporting 19102 but not either of the FNA codes.

Reason: Medicare's Correct Coding Initiative (CCI) edits bundle 10021 as a column 2 code with 10022 and 10022 as a column 2 code with 19102. These CCI edits are under the policy of "sequential procedures," which states that when the physician performs a second procedure because the initial procedure did not successfully

accomplish a medically necessary service, you should report only the more invasive service -- 19102 in this case.

Capture additional fees: Because the surgeon provides the supervision and interpretation of the fluoroscopic guidance, you should list the code (77002) with modifier 26. You should also capture the localization clip placement using +19295.

Diagnosis: You should report the DCIS as 233.0 (Carcinoma in situ of breast).

Phase 2: Lesion Removal for Diagnosis, Treatment

Scenario: Based on DCIS findings, the treating physician schedules the patient for a tumor excision at a later date. In the second encounter, the surgeon uses the radiological clip placed at the earlier session to locate the tumor. During the excision, the surgeon finds that the tumor is not confined to the lactiferous ducts. The surgeon calls for a pathology consultation to assure clear margins.

The pathologist reports tumor present in the medial margin. The surgeon re-excises wide margins. Additionally, the surgeon uses a radioactive tracer to identify the first lymph node that the site of the tumor drains to, and excises an internal mammary sentinel lymph node biopsy before closing the surgical wounds.

Diagnosis: The pathologist diagnoses the specimen as infiltrating ductal carcinoma, and determines that the sentinel lymph node is clear of tumor cells.

Possibilities: Based on the procedures described in the op report, you have the following codes to choose from to describe the surgeon's work:

- 19125 -- Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion
- 19301 -- Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
- 38530 -- Biopsy or excision of lymph node(s); open, internal mammary node(s)
- 38792 -- Injection procedure; radioactive tracer for identification of sentinel node.

Guidelines: Coding breast lesion excision versus lumpectomy may involve gray areas, so use these guidelines to help you choose:

- Use an excision code if the surgeon removes only the tumor and little or no margin. You'll generally see these procedures for smaller, clearly defined lesions that the surgeon believes are not malignant.
- Use a mastectomy code if the surgeon documents attention to removing adequate margins. You're more likely to use these codes for more extensive lesions with probable malignancy.

Solution: You should code the surgeon's work in this case as 19301, 38792, and 38530.

You shouldn't report 19125, even though the documentation supports that the surgeon performed that procedure. "Because the surgeon returned during the same operative session and performed a wide margin excision, you should code the tumor removal as 19301," Bucknam says.

Watch edits: Don't bill 19125 and 19301 together for the same lesion in the same operative session, because CCI bundle these procedures. If the surgeon had performed the 19125 lesion excision and come back at another day to perform the wide margin excision, you could bill for both services by appending modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to 19301.

Capture sentinel node pay: Because the surgeon carried out a sentinel lymph node biopsy using a radiotracer to identify the node, you should code the service in addition to the mastectomy using 38792 and 38530.

Diagnosis: List the final diagnosis of infiltrating ductal carcinoma as 174.2 (Malignant neoplasm of upper-inner quadrant of female breast).