Soft Tissue Biopsy Procedures Utilizing the Spirotome™ Soft-Tissue Biopsy Needle Set

2018 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing soft tissue biopsy procedures utilizing the Spirotome™ Soft-Tissue Biopsy Needle Set.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (http://www.cms.hhs.gov/mcd/search.asp?) and contact their carriers' medical directors (www.cms.hhs.gov/apps/contacts/) or commercial insurers to determine if a procedure is covered.

Coding

Coding for a soft tissue biopsy procedure requires that you report the appropriate biopsy procedure based on the location of the biopsy. The following codes may be reported for a biopsy procedure utilizing the Spirotome™ Soft-Tissue Biopsy Needle Set:

Breast

19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)

NOTE: In 2014 the American Medical Association (AMA) created a new group of image-guided breast biopsy procedure codes. These new codes take into account the type of imaging that is utilized during the breast biopsy procedure. If imaging guidance is used along with the Spirotome Soft-Tissue Needle Set to aid in collection of the breast biopsy specimen, please refer to codes 19081 – 19086 to report the appropriate imaging modality.

Thyroid

60100	Biopsy thyroid, percutaneous core needle

Salivary Gland

42400	Biopsy of salivary gland; needle

Thoracic Wall

32400	Biopsy, pleura, percutaneous needle
32405	Biopsy, lung or mediastinum, percutaneous needle

Abdominal Wall

49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle

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Liver

47000	Biopsy of liver, needle; percutaneous

NOTE: If imaging guidance is performed along with any of the above biopsy procedures (see 76942, 77002, 77012, 77021)

Muscle

20206	Biopsy, muscle, percutaneous needle

Lymph Nodes

38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)

Cervix

58999	Unlisted procedure, female genital system (nonobstetrical)

Submission of a claim with an unlisted code typically requires: (a) a paper claim, (b) the operative note attached to the claim, and (c) a cover letter to the health plan/payer. This cover letter should contain the following information: 1.) identification of comparable procedure(s) to assist the insurer in establishing a payment level and (2) an explanation of the procedure, the patient selection, the medical necessity and the clinical benefits. Unlisted codes are not universally accepted by all insurance carriers. To avoid unnecessary claim denials, we encourage you to contact the payer for its coding recommendations prior to claim submission.

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Payment

2018 Medicare National Average Reimbursement for Soft Tissue Biopsy Procedures Utilizing the Spirotome™ Soft-Tissue Biopsy Needle Set

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT Code	Description	Facility Payment (National Medicare Avg[1])	APC	Facility Payment (National Medicare Avg[2])	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg[3])	Fee When Procedure Is Performed in Office (National Medicare Avg[3])
19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	$542.96	5072	$1,347.94	$72.72	$154.44
20206	Biopsy, muscle, percutaneous needle	$542.96	5072	$1,347.94	$61.20	$241.20
32400	Biopsy, pleura, percutaneous needle	$542.96	5072	$1,347.94	$90.36	$154.44
32405	Biopsy, lung or mediastinum, percutaneous needle	$542.96	5072	$1,347.94	$94.32	$400.68
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	$542.96	5072	$1,347.94	$73.44	$128.88
42400	Biopsy of salivary gland; needle	$76.32	5071	$572.81	$56.16	$107.28
47000	Biopsy of liver, needle; percutaneous	$542.96	5072	$1,347.94	$93.24	$313.56
49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	$542.96	5072	$1,347.94	$88.92	$167.76
58999	Unlisted procedure, female genital system (nonobstetrical)	This service is not included in on Medicare's list of approved procedures	5411	$160.69	Carrier priced procedure	Carrier priced procedure
60100	Biopsy thyroid, percutaneous core needle	$54.00	5071	$572.81	$82.08	$115.92

[1] 2018 Medicare Ambulatory Surgery Center Fee Schedule

[2] 2018 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule

[3] 2018 Medicare Physician Fee Schedule

2018 physician fees for your local area can be found at the following CMS links:

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

or

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at reimbursement@cookmedical.com