



# 2021 Coding Guidance for SCOUT<sup>®</sup>

Prepared by



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Procedure coding should be based upon medical necessity and procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. Merit Medical and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. Contact your local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. Current Procedural Terminology, numeric codes, descriptions, and modifiers are trademarks and copyrights of the AMA.

## INTRODUCTION

The information contained in this document is provided to assist health care facilities in understanding reimbursement guidelines and procedures. It is intended to help obtain accurate coverage and reimbursement for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services and supplies provided, the regulations of insurance carriers and any local, state or federal laws that apply to the supplies and services rendered.

Although a particular service or supply may be considered medically necessary, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

**Always code appropriately based upon procedures performed and medical necessity**

**Be aware of local coverage policies and correct coding initiative quarterly updates**

**Actual reimbursement will vary by geographic region and payer**

**Contact local MAC or payer(s) for specific coding guidelines for any procedure**

**This information is provided for educational purposes only**

## CODING METHODOLOGY

The Physicians' Current Procedural Terminology (CPT®) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party payers. The codes in the CPT Manual are copyrighted by the AMA, and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT coding system for use by providers to communicate payable services. Therefore, it is important to identify the various potential combinations of services to accurately adjudicate claims.

In order for this system to be effective, it is essential the coding description accurately describes what actually transpired at the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event common to all procedures of a similar nature as part of the narrative description for a code. Many of these common activities reflect simply normal principles of medical/surgical care.

## CORRECT CODING INITIATIVE

The CMC developed the National Correct Coding Initiative to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The National Correct Coding Policy edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices.

Quarterly updates are available for hospitals and physicians. Updates can be located on the web at:  
<http://www.cms.hhs.gov/NationalCorrectCodInitEd>

## TERMS, ACRONYMS AND FOOTNOTES

<b>APC</b>	Ambulatory Payment Classification assigned by CMS for hospital payment classification
<b>Contractor Priced</b>	Payment is determined by Medicare Administrator Contractor (MAC)
<b>CMS</b>	Center for Medicare and Medicaid Services
<b>MAC</b>	Medicare Administrator Contractor
<b>MPFS</b>	Medicare Physician Fee Schedule
<b>N/A</b>	Reimbursement not available in this setting/fee schedule by CMS
<b>OPPS</b>	Hospital Outpatient Perspective Payment System
<b>Packaged</b>	Separate payment for this procedure is not made as the service is paid within the primary procedure by CMS
<b>SI</b>	Status Indicator assigned by CMS

### ***Status Indicator(s):***

N = OPPS Items and Services Packaged into Primary Procedure APC Rate

Q1 = Payment is packaged if billed on the same claim as a HCPCS code assigned a status indicator "S", "T" or "V".

J1 = Paid under OPPS; all covered Part B services on the claim are packaged with the primary service for the claim, except services with OPPS SI = F, G, H, L and U

## PROCEDURE CODING

All codes utilized during the patient's course of treatment may not be indicated below. The total course of therapy may consist of patient consultation, surgery, treatment planning, treatment mapping, treatment delivery and management, and follow-up care. Coding for each medically necessary service provided should follow appropriate clinical and coding guidelines. Actual reimbursement will vary by geographic region and payer. Please note the payment rates provided are for Medicare. Payments for commercial/private payers vary based on contract.

## IMPLANT OF RADAR REFLECTOR DEVICE HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4	Description	SI	APC	Hospital Outpatient <sup>1</sup>	ASC	MPFS Facility <sup>2</sup>
<b>Breast – Mammographic Guided Placement</b>						
19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance	Q1	5071	\$621.97 or Packaged*	Packaged	\$100.49
19282	Each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure, use in conjunction with 19281)	N	N/A	Packaged	Packaged	\$50.59
<b>Breast – Stereotactic Guided Placement</b>						
19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance	Q1	5071	\$621.97 or Packaged*	Packaged	\$101.89
19284	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure, use in conjunction with 19283)	N	N/A	Packaged	Packaged	\$51.99
<b>Breast – Ultrasound Guided Placement</b>						
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance	Q1	5071	\$621.97 or Packaged*	Packaged	\$86.19
19286	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure, use in conjunction with 19285)	N	N/A	Packaged	Packaged	\$43.62
<b>Breast – MRI Guided Placement</b>						
19287	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance	Q1	5071	\$621.97 or Packaged*	Packaged	\$128.41
19288	Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure, use in conjunction with 19287)	N	N/A	Packaged	Packaged	\$64.55
<b>Soft Tissue – Image Guided Placement</b>						
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	T	5071	\$621.97	Packaged	\$85.84
10036	each additional lesion	N	N/A	Packaged	Packaged	\$43.62
<b>Radar Reflector</b>						
A4648	Tissue marker, implantable, any type, each	N	N/A	Packaged	Packaged	Not Reported

1. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY2021 Payment Rates (CMS-1736-FC); Addendum B and ASC Addenda.

2. CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1734-IFC); Addendum B. All MPFS Fee Schedules calculated using CF of \$34.8931 effective January 1, 2021.

3. 2021 CPT Professional, ©American Medical Association

\*Status Indicator Q1 dictates that payment is packaged if billed on the same claim as a HCPCS code assigned a status indicator "S", "T", or "V". If you have any additional questions, please contact The Pinnacle Health Group at 866-369-9290 or merit@thepinnaclehealthgroup.com.

# BREAST BIOPSY WITH IMPLANT OF RADAR REFLECTOR DEVICE HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4	Description	SI	APC	Hospital Outpatient <sup>1</sup>	ASC	MPFS Facility <sup>2</sup>
<b>Stereotactic Guided Placement</b>						
19081	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	J1	5072	\$1,407.00	\$594.17	\$167.49
19082	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	N	N/A	Packaged	Packaged	\$84.09
<b>Ultrasound Guided Placement</b>						
19083	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	J1	5072	\$1,407.00	\$594.17	\$158.41
19084	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	N	N/A	Packaged	Packaged	\$78.86
<b>MRI Guided Placement</b>						
19085	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including MRI guidance	J1	5072	\$1,407.00	\$594.17	\$183.54
19086	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	N	N/A	Packaged	Packaged	\$91.77
<b>Lymph Node Biopsy</b>						
38505	Biopsy or excision of lymph nodes; by needle, superficial (eg cervical, inguinal, axillary)	J1	5072	\$1,407.00	\$594.17	\$70.48
<b>Radar Reflector</b>						
A4648	Tissue marker, implantable, any type, each	N	N/A	Packaged	Packaged	Not Reported

1. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY2021 Payment Rates (CMS-1736-FC); Addendum B and ASC Addenda.  
2. CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1734-IFC); Addendum B. All MPFS Fee Schedules calculated using CF of \$34.8931 effective January 1, 2021.

# IMPLANT OF RADAR REFLECTOR DEVICE FREESTANDING FACILITY

CPT-4	Description	MPFS Non-Facility <sup>1</sup>
<b>Breast – Mammographic Guided Placement</b>		
19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance	\$252.63
19282	Each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure, use in conjunction with 19281)	\$180.40
<b>Breast – Stereotactic Guided Placement</b>		
19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance	\$279.14
19284	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure, use in conjunction with 19283)	\$213.20
<b>Breast – Ultrasound Guided Placement</b>		
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance	\$442.44
19286	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure, use in conjunction with 19285)	\$373.71
<b>Breast – MRI Guided Placement</b>		
19287	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance	\$759.97
19288	Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure, use in conjunction with 19287)	\$600.51
<b>Soft Tissue – Image Guided Placement</b>		
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	\$438.61
10036	each additional lesion	\$375.80
<b>Radar Reflector</b>		
A4648	Tissue marker, implantable, any type, each	See Below*

\*Not Paid by Medicare; Private Payers will vary by Contract

## BREAST BIOPSY WITH IMPLANT OF RADAR REFLECTOR DEVICE FREESTANDING FACILITY

CPT-4	Description	MPFS Non-Facility <sup>1</sup>
<b>Stereotactic Guided Placement</b>		
19081	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	\$588.65
19082	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	\$471.41
<b>Ultrasound Guided Placement</b>		
19083	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	\$589.34
19084	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	\$463.03
<b>MRI Guided Placement</b>		
19085	Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including MRI guidance	\$905.48
19086	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	\$717.40
<b>Lymph Node Biopsy</b>		
38505	Biopsy or excision of lymph nodes; by needle, superficial (eg cervical, inguinal, axillary)	\$125.96
<b>Radar Reflector</b>		
A4648	Tissue marker, implantable, any type, each	See Below*

\*Not Paid by Medicare Private Payers will vary by Contract

1. CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1734-IFC); Addendum B. All MPFS Fee Schedules calculated using CF of \$34.8941 effective January 1, 2021.

## RADAR REFLECTOR GUIDANCE (INCLUDES GUIDE AND CONSOLE) HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4	Description	Status Indicator <sup>1</sup>	APC	Hospital Outpatient <sup>1</sup>	Ambulatory Surgery Center <sup>1</sup>	MPFS Facility <sup>2</sup>
19499	Unlisted procedure, breast (e.g., radar reflector surgical guidance)	J1	5091	\$3,157.74	N/A	Contractor Priced by report. Consider crosswalk to 76942, G6001, or G6002
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	J1	5091	\$3,157.74	\$1,176.26	\$475.24
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	J1	5091	\$3,157.74	\$1,176.26	\$680.07
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadectomy	J1	5092	\$5,533.94	\$2,250.70	\$934.79
38500	Biopsy or excision of lymph node(s); open, superficial	J1	5091	\$3,157.74	\$1,176.26	\$262.75
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	J1	5091	\$3,157.74	\$1,176.26	\$453.26

Note: For CY2021, when CPT 19301 is reported on the same claim as either 38500 or 38525, a complexity adjustment is applied. Payment for the two procedures combined will be \$5,533.94.

1. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY2021 Payment Rates (CMS-1736-FC); Addendum B and ASC Addenda.

2. CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1734-IFC); Addendum B. All MPFS Fee Schedules calculated using CF of \$34.8931 effective January 1, 2021.

## COMPLEXITY ADJUSTMENTS

When a procedure assigned a J1 status indicator appears on a Medicare claim, it is assigned to a Comprehensive APC (C-APC). This results in a single payment being made for all other services appearing on the claim, except those with a status indicator of "F", "G", "H", "L" and "U". When more than one procedure with a J1 status indicator appear on a claim, the procedure assigned the highest ranking by CMS (per Addendum J of the annual OPSS final rule) dictates the C-APC that is assigned.

As a means to recognize more costly, complex cases where multiple C-APC procedures are performed during the same surgical session, CMS has established a "complexity adjustment" policy. CMS annually reviews its claims data to determine if certain code combinations must meet specific thresholds for both Cost and Frequency. If these thresholds are met, the code combinations qualify for reassignment to the next highest C-APC in the clinical group. For CY 2021, the following localization, biopsy and lymph node biopsy procedures, when performed together, qualify for a complexity adjustment:

Primary CPT	Primary CPT Descriptor	Primary APC	Secondary CPT	Secondary Descriptor	Secondary APC	Complexity Adj APC	Complexity Adj Payment
19081	Bx breast 1st lesion strtctc	5072	19081	Bx breast 1st lesion strtctc	5072	5073	\$2,370.01
19081	Bx breast 1st lesion strtctc	5072	19082	Bx breast add lesion strtctc	N/A	5073	\$2,370.01
19081	Bx breast 1st lesion strtctc	5072	19083	Bx breast 1st lesion us imag	5072	5073	\$2,370.01
19081	Bx breast 1st lesion strtctc	5072	38505	Needle biopsy lymph nodes	5072	5073	\$2,370.01
19083	Bx breast 1st lesion us imag	5072	19083	Bx breast 1st lesion us imag	5072	5073	\$2,370.01
19083	Bx breast 1st lesion us imag	5072	38505	Needle biopsy lymph nodes	5072	5073	\$2,370.01
19085	Bx breast 1st lesion mr imag	5072	19083	Bx breast 1st lesion us imag	5072	5073	\$2,370.01
19085	Bx breast 1st lesion mr imag	5072	19085	Bx breast 1st lesion mr imag	5072	5073	\$2,370.01
19085	Bx breast 1st lesion mr imag	5072	19086	Bx breast add lesion mr imag	N/A	5073	\$2,370.01
19301	Partial mastectomy	5091	38500	Biopsy/removal lymph nodes	5091	5092	\$5,533.94
38500	Biopsy/removal lymph nodes	5091	19125	Excision breast lesion	5091	5092	\$5,533.94
38525	Biopsy/removal lymph nodes	5091	19125	Excision breast lesion	5091	5092	\$5,533.94



# SCOUT® GUIDE FOR OPERATIVE NOTES

## General Introduction

- Provide basic patient information such as age, gender and diagnosis.
- Explain that a radar reflector was implanted to localize a breast or soft tissue lesion.
- Expand on why this technique was chosen versus wire localization, radioactive seed localization or other localization option.

## The following steps should be included in the operative notes:

### Implant of Radar Reflector and Guidance Device

- How the patient was prepped for the procedure.
- Note type of imaging technique used to identify desired placement location for radar reflector device.
- The type of anesthesia used.
- How the radar reflector device was placed:
  - Type/size of needle used (specify reflector is pre-loaded in needle).
  - Indicate placement was percutaneous and advanced until needle tip was approximately 1 cm beyond the center of the target.
- Confirmation of needle placement with imaging (specify type of imaging used).
- Deployment of radar reflector from the needle and then removal of the needle.
- Confirmation of radar reflector device using imaging (specify type of imaging used).
- Dressing of skin entry site and any patient counseling provided.

### Radar Reflector Guidance

- Describe setup of the surgical guidance system for locating the previously implanted radar reflector.
- Detail how the Guide (handpiece) is placed on the skin over the general location of radar reflector and that the area is slowly scanned until radar reflector is located.
- Note how the area for excision is marked and correlated with the preoperative localization film.
- Note how skin incision was planned and area prepped with local anesthesia (if used).
- Explain how Guide is used during and throughout excision for real-time guidance and continuous adjustment of the direction to the radar reflector.
- Note that the Guide is applied to the excised tissue specimen to confirm removal of the radar reflector within the specimen.
- If specimen radiography is performed to further confirm removal of the radar reflector, lesion and adequate margins, it should be included in the notes.
- Specify how wound is closed and dressed.
- Note any additional patient counseling provided.

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Before using refer to Instructions for Use for indications, contraindications, warnings, precautions, and directions for use.



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