2016 Coding Guidance for SAVI SCOUT®

SAVI SCOUT®

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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 carriers. 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 Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to ensure that payment policies and procedures were standardized for all MACs and to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the American Medical Association'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

APC	Ambulatory Payment Classification assigned by CMS for hospital payment classification
Carrier Priced	Payment is determined by Medicare Administrator Contractor (MAC)
CMS	Center for Medicare and Medicaid Services
MAC	Medicare Administrator Contractor
N/A	Reimbursement not available in this setting/fee schedule by CMS
OPPS	Hospital Outpatient Perspective Payment System
Packaged	Separate payment for this procedure is not made as the service is paid within the primary procedure by CMS
SI	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 date of service as a HCPCS code assigned a status indicator "S", "T" or "V".

S = Significant Procedure, not discounted when multiple

T = Paid separately under OPPS; Significant Procedure, Multiple Reduction Applies

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 Infrared-Activated, Micro-Impulse Radar Reflector Device

HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4®	Description	SI	APC	Hospital Outpatient[1]	ASC	Physician Professional[2]
	Mammographic Guided Placement					
19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance	Q1*	5072	$480.64 or Packaged*	Packaged	$104.91
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	$52.63
	Stereotactic Guided Placement					
19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance	Q1*	5072	$480.64 or Packaged*	Packaged	$105.62
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	$53.35
	Ultrasound Guided Placement					
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance	Q1*	5072	$480.64 or Packaged*	Packaged	$89.51
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	$45.11
	MRI Guided Placement					
19287	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance	Q1*	5072	$480.64 or Packaged*	Packaged	$134.27
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	$66.95
	Micro-Impulse Radar Reflector					
A4648**	Tissue marker, implantable, any type, each	N	N/A	Packaged	Packaged	Not Reported

**Status Indicator Q1 dictates that payment is packaged if billed on the same date of service 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 cianna@thepinnaclehealthgroup.com.*

***A4648 may be reported to track utilization and cost. Reimbursement will be based on the individual provider contract with payers. Please note that most payers consider reimbursement for A4648 to be included in the primary procedure reported.*

1. HOPPS and ASC Payment Systems and Quality Reporting Programs, 80 FR 70297, November 13, 2015. Addendum AA – Final ASC Covered Surgical Procedures for CY 2016. Addendum B – Final OPPS Payment by HCPCS Code.

2. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 FR 70885, November 16, 2015. Addendum B – Relative Value Units and Related Information Used in CY 2016 Final Rule. All MPFS Fee Schedules calculated using CF of $35.8279 effective January 1, 2016.

Implant of Infrared-Activated, Micro-Impulse Radar Reflector Device

FREESTANDING FACILITY

CPT-4®	Description	Physician Global[1]
	Mammographic Guided Placement	
19281	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including mammographic guidance	$243.47
19282	Each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure, use in conjunction with 19281)	$170.43
	Stereotactic Guided Placement	
19283	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including stereotactic guidance	$273.90
19284	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure, use in conjunction with 19283)	$206.59
	Ultrasound Guided Placement	
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including ultrasound guidance	$523.46
19286	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure, use in conjunction with 19285)	$459.73
	MRI Guided Placement	
19287	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, first lesion, including magnetic resonance guidance	$875.06
19288	Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure, use in conjunction with 19287)	$704.70
	Micro-Impulse Radar Reflector	
A4648**	Tissue marker, implantable, any type, each	By Contract*

** Reimbursement will be based on the individual provider contract with payers. Medicare CR6968 states A4648 is separately billable when reported with 19499, 32553, 49411, and 55876 only. Most other payers consider reimbursement for A4648 to be included in the primary procedure reported. Check with your local payers to ascertain the terms of your contract. A4648 may be reported to track utilization and cost.*

1. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 FR 70885, November 16, 2015. Addendum B – Relative Value Units and Related Information Used in CY 2016 Final Rule. All MPFS Fee Schedules calculated using CF of $35.8279 effective January 1, 2016.

Infrared-Activated, Micro-Impulse Radar Reflector Guidance (includes Handpiece and Console)

HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4®	Description	Status Indicator	APC	Hospital Outpatient[1]	Ambulatory Surgery Center[1]	Physician Professional[2]
19499	Unlisted procedure, breast (e.g., radar reflector surgical guidance)	T	5091	$2,187.94	N/A	Carrier 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	T	5091	$2,187.94	$1,223.47	$473.33
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	T	5091	$2,187.94	$1,223.47	$673.48
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadectomy	T	5092	$3,647.06	$2,039.38	$928.05
38500	Biopsy or excision of lymph node(s); open, superficial	T	5091	$2,187.94	$1,223.47	$263.16
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	T	5091	$2,187.94	$1,223.47	$452.21

1. HOPPS and ASC Payment Systems and Quality Reporting Programs, 80 FR 70297, November 13, 2015. Addendum AA – Final ASC Covered Surgical Procedures for CY 2016. Addendum B – Final OPPS Payment by HCPCS Code.

2. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 FR 70885, November 16, 2015. Addendum B – Relative Value Units and Related Information Used in CY 2016 Final Rule. All MPFS Fee Schedules calculated using CF of $35.8279 effective January 1, 2016.

SAVI SCOUT® Guide for Operative Notes

General Introduction

Provide basic patient information such as age, gender and diagnosis.

Explain that an infrared-activated, micro-impulse radar reflector was implanted for surgical guidance of a non-palpable breast lesion.

Expand on why this technique was chosen versus wire or radioactive seed localization.

The following steps should be included in the operative notes:

Implant of Infrared-Activated, Micro-Impulse 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 infrared-activated, micro-impulse radar reflector device—reported separately (76492 or 76499)
- 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 1cm 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.

Infrared-Activated, Micro-Impulse Radar Reflector Guidance

- Describe setup of the surgical guidance system for locating the previously implanted infrared-activated, micro-impulse radar reflector.
- Detail how the 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 handpiece is used during and throughout excision for real-time guidance and continuous adjustment of the direction to the radar reflector.
- Note that the handpiece 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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