Balloon Catheter Implant/ Excisional Breast Surgery

Global and Physician Professional Payment

Balloon Catheter Implant

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	Office/Freestanding (Global)	113.16	$4,073.71
		Facility (Professional)	6.09	$219.24
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Office/Freestanding (Global)	NA	NA
		Facility (Professional)	2.74	$98.64

Excisional Breast Surgery

CPT Code[1]	Description	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	Office/Freestanding (Global)	15.68	$564.47
		Facility (Professional)	13.20	$475.19
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)	Office/Freestanding (Global)	NA	NA
		Facility (Professional)	18.77	$675.71
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Office/Freestanding (Global)	NA	NA
		Facility (Professional)	25.88	$931.67
19499	Unlisted procedure, breast	Office/Freestanding (Global)	NA	Determined by contractors
		Facility (Professional)		

Site of Service[4]

Site of Service Code	Site of Service Name	Site of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
2. The 2018 physician relative value units (RVUs) are from the latest 2018 RVU file available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending.
3. The national average 2018 Medicare rates to physicians shown are based on the 2018 conversion factor of $35.9996 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2018 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
4. AMA, 2018 CPT, Professional Edition.

Balloon Catheter Implant/ Excisional Breast Surgery

Facility Payment

Balloon Catheter Implant

CPT®/HCPCS Code[1]	Description	Site of Service[2]	APC[2]	Status Indicator[2]	2018 National Average Medicare Rate[2]
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	Hospital	5093	J1	$7,387.22
		ASC	NA	J8	$3,683.98
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Hospital	NA	N	Packaged
		ASC		N1	Packaged
C1728	Catheter, brachytherapy seed administration.	Hospital	NA	N	Packaged
		ASC		N1	

Excisional Breast Surgery

CPT®/HCPCS Code[1]	Description	Site of Service[2]	APC[2]	Status Indicator[2]	2018 National Average Medicare Rate[2]
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	Hospital	5091	J1	$2,727.65
		ASC	5091	A2	$1,030.13
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)	Hospital	5091	J1	$2,727.65
		ASC	5091	A2	$1,030.13
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Hospital	5092	J1	$4,811.54
		ASC	5092	A2	$2,046.34
19499	Unlisted procedure, breast	Hospital	5091	J1	$2,727.65
		ASC	NA	NA	NA

Supplies

CPT®/HCPCS Code[1]	Description	Site of Service[2]	APC[2]	Status Indicator[2]	2018 National Average Medicare Rate[2]
A4550	Surgical trays	Hospital	NA	B	Not paid under OPPS May be subject to review for payment by commercial payer/health plan
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Hospital	NA	B	Not paid under OPPS May be subject to review for payment by commercial payer/health plan

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
2. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

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Balloon Catheter Implant/ Excisional Breast Surgery

Facility Payment

Status and Payment Indicator Information[1]

Status and Payment Indicator	Explanation
HOPPS Status Indicator	
B	Not paid under OPPS
J1	Comprehensive APC paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with status indicator "F", "G", "H", "L" and "U"
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
T	Paid separately under OPPS but multiple procedure reduction applies
ASC Payment Indicator	
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
N1	Packaged service/item; no separate payment made

Modifier information[2]

CPT code 19296 is typically performed during the post-operative period of a lumpectomy or partial mastectomy, therefore claim processing systems might deny a claim for CPT code 19296 as related to the lumpectomy or partial mastectomy. To avoid this potential problem, it may be necessary to append a modifier to CPT code 19296 indicating special circumstances apply. Please contact your local carrier/health plan/payer organizations to obtain a list of approved modifiers. Modifiers that may be applicable include:

Modifier	Description	Explanation
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/ procedure room (eg, unanticipated clinical condition), see modifier 78.
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operation/procedure room, it may be reported by added modifier 78 to the related procedure.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

1. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
2. AMA, 2018 CPT, Professional Edition.

Hologic Inc., provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which codes and modifiers to use for a particular service, supply, procedure or treatment. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Contact your local payer for specific coding and coverage guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide.

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