PERCUTANEOUS IMAGE-GUIDED BREAST BIOPSY
(NCD 220.13)

Guideline Number: MPG236.04

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TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®)**, Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member’s benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

**CPT® is a registered trademark of the American Medical Association.

PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.
UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

POLICY SUMMARY

Overview
Percutaneous image-guided breast biopsy is a method of obtaining a breast biopsy through a percutaneous incision by employing image guidance systems. Image guidance systems may be either ultrasound or stereotactic.

The Breast Imaging Reporting and Data System (or BIRADS system) employed by the American College of Radiology provides a standardized lexicon with which radiologists may report their interpretation of a mammogram. The BIRADS grading of mammograms is as follows: Grade I-Negative, Grade II-Benign finding, Grade III-Probably benign, Grade IV-Suspicious abnormality, and Grade V-Highly suggestive of malignant neoplasm.

Guidelines
Nonpalpable Breast Lesions
Effective January 1, 2003, Medicare covers percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for a radiographic abnormality that is nonpalpable and is graded as a BIRADS III, IV, or V.

Palpable Breast Lesions
Effective January 1, 2003, Medicare covers percutaneous image guided breast biopsy using stereotactic or ultrasound imaging for palpable lesions that are difficult to biopsy using palpation alone. Contractors have the discretion to decide what types of palpable lesions are difficult to biopsy using palpation.

APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<th>CPT Code</th>
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<td>10022</td>
<td>Fine needle aspiration; with imaging guidance</td>
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<td>19081</td>
<td>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</td>
</tr>
<tr>
<td>19082</td>
<td>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; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)</td>
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<td>19083</td>
<td>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</td>
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<td>19084</td>
<td>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; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)</td>
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<tr>
<td>19085</td>
<td>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 magnetic resonance guidance</td>
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<td>19086</td>
<td>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; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)</td>
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REFERENCES

CMS National Coverage Determinations (NCDs)
NCD 220.13 Percutaneous Image-Guided Breast Biopsy

CMS Benefit Policy Manual
Chapter 15; § 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, § 260 Ambulatory Surgical Center Services

CMS Claims Processing Manual
Chapter 12; § 90.3 Physicians’ Services Performed in Ambulatory Surgical Centers (ASC)
Chapter 13; § 80.1 Physician Presence, § 80.2 Multiple Procedure Reduction
Chapter 14; § 10 General

CMS Transmittals
Transmittal 159, Change Request 2232, Dated 09/27/2002
Transmittal 1419, Change Request 5865, Dated 01/18/2008 (January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0)
Transmittal 1975, Change Request 10318, Dated 11/09/2017 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 2005, Change Request 10318, Dated 01/18/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 2636, Change Request 7501, Dated 01/16/2013 (National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION)

MLN Matters
Article MM10318, ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)

Others
Program Memorandum Intermediaries/Carriers, Transmittal AB-02-128, Change Request 2232, Dated 09/27/2002 (Coverage and Billing for Percutaneous Image-Guided Breast Biopsy)

GUIDEline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<th>Date</th>
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<td>06/13/2018</td>
<td>• Administrative updates</td>
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