2024 Coding Guidance for SCOUT®

Prepared by

merit@thepinnaclehealthgroup.com
866-369-9290

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

APC	Ambulatory Payment Classification assigned by CMS for hospital payment classification
Contractor Priced	Payment is determined by Medicare Administrator Contractor (MAC)
CMS	Center for Medicare and Medicaid Services
MAC	Medicare Administrator Contractor
MPFS	Medicare Physician Fee Schedule
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 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
PI	Payment Indicator ***Payment Indicator(s):*** A2 = Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight N1 = Packaged

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.

PLACEMENT OF BREAST LOCALIZATION DEVICE(S)

HOSPITAL OUTPATIENT AND ASC SETTING

Please note that lumpectomy and biopsy procedures are assigned a "J1" status indicator which results in all other services on the claim to be packaged except those with a status indicator of "F", "G", "H", "L", and "U". As such, if the breast localization code appears on the same claim as the lumpectomy or biopsy procedure, payment for the localization code will be packaged (i.e., there is no separate payment).

CPT	Description	OPPS			ASC		Physician
		SI	APC	Payment	PI	Payment	MPFS
Breast – 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	$1,545 or Packaged*	N1	Packaged	$95
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	N1	Packaged	$47
Breast – 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	5071	$670 or Packaged*	N1	Packaged	$96
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	N1	Packaged	$48
Breast – 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	5071	$670 or Packaged*	N1	Packaged	$81
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	N1	Packaged	$41
Breast – 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	5071	$670 or Packaged*	N1	Packaged	$121
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	N1	Packaged	$60
Soft Tissue – Image Guided Placement							
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	T	5071	$670	N1	Packaged	$81
10036	Each additional lesion	N	N/A	Packaged	N1	Packaged	$41
Radar Reflector							
A4648	Tissue marker, implantable, any type, each	N	N/A	Packaged	N1	Packaged	Not Reported

BREAST AND LYMPH NODE BIOPSY

HOSPITAL OUTPATIENT AND ASC SETTING

ASC Special Payment Policy for OPPS C-APCs

In CY 2023, CMS established an ASC Special Payment Policy for OPPS Complexity-Adjusted Comprehensive Ambulatory Payment Classifications (C–APCs) for primary surgical procedure and packaged add-on code combinations that are eligible for complexity adjustments under the OPPS and also performed in the ASC. New C-codes were established to report the code combinations that qualify the complexity adjustment to ASCs when these specific code pairs are performed. When the assigned primary procedure and secondary add-on procedure HCPCS codes are performed together during an encounter, ASCs should now bill the new C-code to which these procedures are paired rather than the individual procedures HCPCS codes.

There are two biopsy code combinations qualify for this ASC payment adjustment:

1. 19081 and 19082; and
2. 19085 and 19085.

ASCs should now report C7501 when more than one lesion is biopsied using stereotactic imaging (19081 and 19082) and C7502 when more than one lesion is biopsied using MRI imaging (19085 and 19086).

CPT	Description	OPPS			ASC		Physician
		SI	APC	Payment	PI	Payment	MPFS
Stereotactic Guided Placement							
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	$1,545	G2	$683	$157
19082	Each additional lesion, including MRI guidance(List separately in addition to code for primary procedure)	N	N/A	Packaged	N/A	N/A	$79
C7501	Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral and bilateral (for single lesion biopsy, use appropriate code)	E1	N/A	N/A	G2	$1,157	N/A
Ultrasound Guided Placement							
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	$1,545	G2	$683	$148
19084	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	N	N/A	Packaged	N1	Packaged	$74
MRI Guided Placement							
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	$1,545	G2	$683	$172
19086	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	N	N/A	Packaged	N/A	N/A	$86
C7502	Percutaneous breast biopsies using magnetic resonance guid¬ance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral or bilateral (for single lesion biopsy, use appropriate code)	E1	N/A	N/A	G2	$1,157	N/A
Lymph Node Biopsy							
38505	Biopsy or excision of lymph nodes; by needle, superficial (eg cervical, inguinal, axillary	J1	5072	$1,545	G2	$683	$83
Radar Reflector							
A4648	Tissue marker, implantable, any type, each	N	N/A	Packaged	N1	Packaged	Not Re-ported

PLACEMENT OF LOCALIZATION DEVICE(S)

FREESTANDING/OFFICE SETTING

CPT	Description	Physician
Breast – 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	$236
19282	Each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure, use in conjunction with 19281)	$167
Breast – 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	$253
19284	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure, use in conjunction with 19283)	$185
Breast – 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	$357
19286	Each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure, use in conjunction with 19285)	$292
Breast – 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	$616
19288	Each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure, use in conjunction with 19287)	$474
Soft Tissue – Image Guided Placement		
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	$354
10036	Each additional lesion	$290
Radar Reflector		
A4648	Tissue marker, implantable, any type, each	See Below*

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

BREAST AND LYMPH NODE BIOPSY

FREESTANDING/OFFICE SETTING

CPT	Description	Physician
Stereotactic Guided Placement		
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	$487
19082	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	$374
Ultrasound Guided Placement		
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	$485
19084	Each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	$368
MRI Guided Placement		
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	$742
19086	Each additional lesion, including MRI guidance (List separately in addition to code for primary procedure)	$574
Lymph Node Biopsy		
38505	Biopsy or excision of lymph nodes; by needle, superficial (eg cervical, inguinal, axillary)	$171
Radar Reflector		
A4648	Tissue marker, implantable, any type, each	See Below*

*Not Paid by Medicare Private Payers will vary by Contract

BREAST EXCISION CODES

HOSPITAL OUTPATIENT AND ASC SETTING

CPT	Description	OPPS			ASC		Physician
		SI	APC	Payment	PI	Payment	MPFS
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	J1	5091	$3,632	A2	$1,469	$458
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	J1	5091	$3,632	A2	$1,469	$653
19302	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadectomy	J1	5092	$6,213	A2	$2,536	$896
19499	Unlisted procedure, breast*	E1	N/A	N/A	N/A	N/A	By Report
38500	Biopsy or excision of lymph node(s); open, superficial	J1	5091	$3,632	A2	$1,469	$252
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	J1	5091	$3,632	A2	$1,469	$437

Note: For CY2024, when CPT 19301 is reported on the same claim as either 38500 or 38525, a complexity adjustment is applied. Payment for the two procedures combine will be $6,213.

*Physicians may report CPT 19499 for professional payment to reflect use of the access guide/probe to identify the location of the Scout reflector. CPT 76942, G6001, or G6002 may be considered as crosswalks for payment purposes. It should not be reported by facilities.

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 statue indicator of "F", "G", "H", "L" and "U". When more than one procedure with a J1 status indicator appear on a claim, the procedure is assigned the highest ranking by CMS (per Addendum J of the annual OPPS 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 2024, 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	$2,707
19081	Bx breast 1st lesion strtctc	5072	19082	Bx breast add lesion strtctc	N/A	5073	$2,707
19081	Bx breast 1st lesion strtctc	5072	19083	Bx breast 1st lesion us imag	5072	5073	$2,707
19081	Bx breast 1st lesion strtctc	5072	38505	Needle biopsy lymph nodes	5072	5073	$2,707
19083	Bx breast 1st lesion us imag	5072	38505	Needle biopsy lymph nodes	5072	5073	$2,707
19085	Bx breast 1st lesion mr imag	5072	19083	Bx breast 1st lesion us imag	5072	5073	$2,707
19085	Bx breast 1st lesion mr imag	5072	19085	Bx breast 1st lesion mr imag	5072	5073	$2,707
19085	Bx breast 1st lesion mr imag	5072	19086	Bx breast add lesion mr imag	N/A	5073	$2,707
19301	Partial mastectomy	5091	38500	Biopsy/removal lymph nodes	5091	5092	$6,213
38500	Biopsy/removal lymph nodes	5091	19125	Excision breast lesion	5091	5092	$6,213
38525	Biopsy/removal lymph nodes	5091	19125	Excision breast lesion	5091	5092	$6,213

REFERENCES:

1. CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule (CMS-1786-FC); Addendum B, Addendum J, and ASC Addenda.
2. CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1784-F); Addendum B. All MPFS Fee Schedules calculated using CF of $32.7442 effective January 1, 2024. Please note, payments rates may be subject to change pending legislation (H.R.6683 - Preserving Seniors' Access to Physicians Act of 2023).
3. DRG values were calculated using a base rate of $6,497.77and Capital Standard Payment of $503.85. The base payment rate assumes the hospital submitted quality data and is a user of EHR. The weighted rate used the 10% Cap Applied. hospital's base payment rate will change if the hospital does not meet either or both of these measures. Calculations were based on data provided in FY 2024 IPPS Final Rule CN (Tables 1A, 1D, and 5CN).
4. 2024 CPT Professional, ©2023 American Medical Association

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 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.

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.

CPT® is a registered trademark of the American Medical Association

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

Understand. Innovate. Deliver.™

merit.com

Merit Medical Systems, Inc.
1600 West Merit Parkway
South Jordan, Utah 84095
1.801.253.1600
1.800.35.MERIT

Merit Medical Europe, Middle East & Africa (EMEA)
Amerikalaan 42, 6199 AE
Maastricht-Airport
The Netherlands
+31 43 358 82 22

Merit Medical Ireland Ltd.
Parkmore Business Park West
Galway, Ireland
+353 (0) 91 703 733

©2024 Merit Medical Systems, Inc. All rights reserved.

405133001_008 ID 020924