Breast Biopsy

Global and Physician Professional Payment

CPT® Code[1]	Description	Site of Service Component	RVU[2]	2019 National Average Medicare Rate[3]
Stereotactic guided breast biopsy				
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Office/Freestanding (Global)	18.42	$663.84
		Facility (Professional)	4.85	$174.79
19082	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Office/Freestanding (Global)	15.03	$541.67
		Facility (Professional)	2.44	$87.94
Ultrasound guided breast biopsy				
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	Office/Freestanding (Global)	18.04	$650.15
		Facility (Professional)	4.57	$164.70
19084	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Office/Freestanding (Global)	14.49	$522.21
		Facility (Professional)	2.28	$82.17
MRI guided breast biopsy				
19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	Office/Freestanding (Global)	27.39	$987.11
		Facility (Professional)	5.30	$191.01
19086	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Office/Freestanding (Global)	21.97	$791.78
		Facility (Professional)	2.65	$95.50

Additional information: 1. The "additional lesion" codes **(19082, 19084, 19086)** are reported for biopsy of additional lesions within the **same or contra-lateral** breast on the same date of service. *Example: Patient has two lesions in the right breast and is undergoing an ultrasound guided biopsy – code 19083 (1st lesion) and 19084 (2nd lesion).* **2.** If two lesions are biopsied using different imaging modalities either in the same or opposite breast, two base codes are assigned, one for each modality. These add-on codes may be assiged only if the same modality is used for additional lesions. **3.** In the Hospital Outpatient setting the new breast biopsy "additional lesion" codes are packaged or captured in the primary breast biopsy codes, and only the physician performing the "additional lesion" procedure is reimbursed separately when billing an "additional lesion" code.

1. American Medical Association (AMA), 2019 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2018 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), 2019 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
2. The 2019 physician relative value units (RVUs) are from the January 2019 RVU file (RVU19A) 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 2019 Medicare rates to physicians shown are based on the 2019 conversion factor of $36.0391 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2019 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.

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Breast Biopsy

Facility Payment

CPT® Code/ HCPCS Code[1]	Description	Site of Service Component	APC[2]	Status Indicator[2]	2019 National Average Medicare Rate[2]
Stereotactic guided breast biopsy					
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Hospital	5072	J1	$1,375.50
		ASC	5072	G2	$546.90
19082	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Ultrasound guided breast biopsy					
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneouss; first lesion, including ultrasound guidance	Hospital	5072	J1	$1,375.50
		ASC	5072	G2	$546.90
19084	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
MRI guided breast biopsy					
19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance	Hospital	5072	J1	$1,375.50
		ASC	5072	G2	$546.90
19086	Biopsy, breast, with placement of breast localization device(s) (eg, 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)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
Supplies					
A4649	Surgical supply; miscellaneous	Hospital/ASC	NA	N	Packaged
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/ASC	NA	B	Not paid under OPPS. May be subject to review for payment by commercial payers.

Additional information: 1. The "additional lesion" codes **(19082, 19084, 19086)** are reported for biopsy of additional lesions within the **same or contra-latera**l breast on the same date of service. *Example: Patient has two lesions in the right breast and is undergoing an ultrasound guided biopsy – code 19083 (1st lesion) and 19084 (2nd lesion).* **2.** If two lesions are biopsied using different imaging modalities either in the same or opposite breast, two base codes are assigned, one for each modality. The add-on codes may be assigend only if the same modality is used for additional lesions. **3.** In the Hospital Outpatient setting the new breast biopsy "additional lesion" codes are packaged or captured in the primary breast biopsy codes, and only the physician performing the "additional lesion" procedure is reimbursed separately when billing an "additional lesion" code.

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2. The national average 2019 Medicare rates for the hospital outpatient setting are from the 2019 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum B, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. The national average 2019 Medicare rates for the ambulatory surgical center setting are from the 2019 Ambulatory Surgical Center Payment Final Rule, Addenda AA and BB, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. 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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Status and Payment Indicator Information[1]

Status and Payment Indicator	Explanation
HOPPS Status Indicator	
B	Not paid under OPPS
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
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"
ASC Payment Indicator	
G2	Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight
N1	Packaged service/item; no separate payment made

1. The national average 2019 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2019, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2019 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 2019, 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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