



## 2010 Medicare Billing and Payment Information

### Core Needle Biopsy Reimbursement

#### Hospital Outpatient Department (Medicare Billing)<sup>1</sup>

- Breast Center (Hospital Owned) - Imaging Center (Hospital Owned)  
 - Radiology Department (Hospital) - Department (Hospital Outpatient)

#### Facility Billing

Rev. Code	Description	HCPCS	APC	Status Indicator	2010 Medicare APC Payment
310/312	Pathology Lab (Surg. Path IV)	88305	0343	X	\$35.73
402 <sup>2</sup>	Ultrasonic Guidance <sup>3</sup>	76942		N	Bundled
402 <sup>2</sup>	Upright Mammography	77032		N	Bundled
402 <sup>2</sup>	Stereotactic Imaging Guidance	77031		N	Bundled
402	Echo Breast (Image Documentation)	76645	0265	S	\$62.47
402	Radiological Exam, Specimen	76098	0260	Q2	\$377.55
401	Unilateral Mammogram (Post Procedure)	77055	0271	A	Payment method other than OPSS
36X or 49X or 51X	Operating Room or Ambulatory Surgery or Clinic Services (Breast Biopsy)	19102 19295 (Marker)	0005	T N	\$526.74 Bundled

Note: X represents a third digit between 0 and 9

#### Physician Billing

CPT	Description	2010 Medicare Fee Schedule Payment (4,5)
19102	Percutaneous, Needle Core Biopsy	\$103.20
76942-26	Ultrasonic Guidance - Professional Component	\$33.92
77032-26	Upright Mammography Guidance - Professional Component	\$28.15
77031-26	Stereotactic Localization Guidance - Professional Component	\$80.83
76645-26	Echography, Breast with Image Documentation - Professional Component	\$27.42
77055-26	Unilateral Mammogram (post-procedure) - Professional Component	\$35.36
76098-26	Radiological Exam, Specimen	\$8.30
19295	Tissue Marker Placement	\$0.00

PLUS APPROPRIATE EVALUATION AND MANAGEMENT CODES

<sup>1</sup> Hospital outpatient reimbursement from Medicare for this procedure is based on the 2010 Hospital Outpatient Prospective Payment System, November 20, 2009 *Federal Register*. Reimbursement from private/commercial payers is applied on a case-by-case basis depending on the patient's insurance and the type of contract the hospital has signed with that specific insurance company. All rates shown are national average Medicare rates for 2010. These rates have not been adjusted for geographic variations in costs.

<sup>2</sup> Revenue codes are required on the UB-40 billing form to represent the type of services provided. Most but not all revenue codes require corresponding HCPCS codes. (Source - Hospital Charge Master Guide, St. Anthony Publishing, 1999)

<sup>3</sup> Medicare lists Ultrasound Guidance for Breast Biopsy as an interventional radiology procedure. Interventional procedures are coded into separate procedural components using surgical CPT codes (19000 series) and radiological CPT codes (70000 series). (Hospital Charge Master Guide, St. Anthony Publishing, 1999) Consult your local payers about their coding policies.

<sup>4</sup> Medicare national average physician payments are calculated using the 2010 Conversion Factor of \$36.0846, which is effective from January 1 - February 28, 2010. Congress will again have to act by February 28, 2010 to ensure that physician payment is not cut for the remainder of 2010 by 21.2%. These national average Medicare rates have not been adjusted for geographic variations. Source: 2010 Final Medicare Physician Fee Schedule, November 25, 2009 *Federal Register*.

<sup>5</sup> Per the Deficit Reduction Act of 2006, Medicare payments for imaging procedures that are billed by a physician office, an IDTF, or a Free-Standing Imaging Facility are capped for the technical component at the lesser of the Medicare Physician Fee Schedule or the Hospital Outpatient Rate starting January 1, 2007.

DISCLAIMER - The information contained in this document is provided to help you understand the reimbursement process as it pertains to SenoRx products and services that may be provided in conjunction with the use of a SenoRx product. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not a comprehensive statement of all of the laws, regulations, rules, policies or other resources that may affect reimbursement. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that providers consult their Medicare contractors and private payers with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by SenoRx, Inc. concerning levels of reimbursement, payment of charge. Similarly, all CPT & APC codes are supplied for information purposes only and represent no statement, promise or guarantee by SenoRx, Inc. that these codes will be appropriate or that reimbursement will be made. CPT codes and descriptions only are copyright 2010 American Medical Associations. All rights reserved. CPT does not include fee schedules relative values or related ratings. The source for this information is the Centers for Medicare and Medicaid Services. Information current as of February 2010. The content provided by the Center for Medicare and Medicaid Services is updated frequently. SenoRx is not committing to updating this information, which may change and may stop providing this information at its sole discretion at any time. It is the responsibility of the health services provider to confirm the appropriate coding required by their local Medicare contractors and private payers. The health service provider assumes all risk related to reimbursement for SenoRx products and related services that customer provides, and SenoRx assumes no responsibility for the customer's reimbursement, if any.

(2010 Medicare Hospital Outpatient Prospective Payment System, Ambulatory Payment Classification (APC) Payment Levels Effective January 1, 2010.  
 2010 Physician Payment Levels Effective January 1 - February 28, 2010.  
 2010 Ambulatory Surgery Center (ASC) Payment Levels Effective January 1, 2010)



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### Core Needle Biopsy Reimbursement

#### **Free-Standing Ambulatory Surgery Center Billing**

CPT	Description	Status Indicator	2010 Medicare APC Payment <sup>(6,7)</sup>
19102	Percutaneous, Needle Core Biopsy	A2	\$272.19
19295	Tissue Marker Placement	N	Bundled
76942	Ultrasonic Guidance	N	Bundled
77032	Upright Mammography Guidance	N	Bundled
77031	Stereotatic Guidance	N	Bundled
76645	Echography, Breast	Z2	\$37.12
77055	Unilateral Mammogram	A2	Not on approved list
76098	Radiological Exam: Specimen	N1	Bundled

#### **Global Billing**

- Physician Owned Breast Center
- Doctor's Office/Clinic
- Imaging Center (Radiologist-Owned)

CPT	Description	2010 Medicare Fee Schedule Payment <sup>(4,5)</sup>
19102	Percutaneous, Needle Core Biopsy	\$204.96
76942	Ultrasonic Guidance	\$181.87
77032	Upright Mammography Guidance	\$55.57
77031	Stereotactic Localization Guidance	\$168.52
76645	Echography, Breast with Image Documentation	\$89.85
76098	Radiological Exam, Specimen	\$19.12
77055	Unilateral Mammogram (post-procedure)	\$82.63
19295	Tissue Marker Placement	\$84.08
A4550 99070 or A4649 <sup>(8)</sup>	Surgical Supplies (Probe, Marker, etc.) (Private Payers Only)	Payer Dependent

PLUS APPROPRIATE EVALUATION AND MANAGEMENT CODES

4 Medicare national average physician payments are calculated using the 2010 Conversion Factor of \$36.0846, which is effective from January 1 - February 28, 2010. Congress will again have to act by February 28, 2010 to ensure that physician payment is not cut for the remainder of 2010 by 21.2%. These national average Medicare rates have not been adjusted for geographic variations. Source: 2010 Final Medicare Physician Fee Schedule, November 25, 2009 *Federal Register*.

5 Per the Deficit Reduction Act of 2006, Medicare payments for imaging procedures that are billed by a physician office, an IDTF, or a Free-Standing Imaging Facility are capped for the technical component at the lesser of the Medicare Physician Fee Schedule or the Hospital Outpatient Rate starting January 1, 2007.

6 Source: 2010 Medicare ASC Payment Final Rule, November 20, 2009 and December 31, 2009 *Federal Register*.

7 ASC rates are based on the 2010 Final Medicare ASC Rule, November 20, 2009 and December 31, 2009 *Federal Register*.

8 Medicare does not recognize 99070 or A4649 as a separate supply code.

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