



Suggested Guidelines for Reimbursement for Bone Marrow Aspiration and Biopsy

Medicare Reimbursement

Unique Medicare pass through code and payment *now* available for use of OnControlTM for Medicare eligible patients in the hospital outpatient and ambulatory surgery center (ASC) settings – effective October 1, 2011.

BONE MARROW ASPIRATION AND BIOPSY USING GUIDANCE

Coverage

Medicare, other governmental reimbursement programs and other third party payers (e.g. private insurers) generally cover bone marrow aspiration and/or biopsy procedures; and also cover the use of imaging guidance (e.g. fluoroscopy, ultrasound, or CT) for aspiration/biopsy procedures. Coverage for these services varies by payer, and may or may not be available depending upon the payer, site of service (e.g. hospital outpatient, physician office), and the indication. Each provider and recipient of these services is responsible to ensure that coverage is available for such procedures and Vidacare assumes no liability for non-coverage of services. It is therefore important that providers contact the payer to determine if these services are covered and that patients contact their insurer to determine if their health insurance policy covers these services. Effective October 1, 2011, Medicare will be covering and paying for a new pass through code for use of the OnControl biopsy needle when used on Medicare eligible patients in both the hospital outpatient and ambulatory surgery settings. See payment policies herein for how OnControl will be reimbursed. This new code is C1830 and its code descriptor is: Power bone marrow biopsy needle. Please ensure that this code and the appropriate charge are entered on to the hospital chargemaster.

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Coding

Each provider is legally responsible to ensure that all coding for reimbursement under federal reimbursement or commercial programs is recorded and submitted appropriately and within the legal and contractual parameters permissible for reimbursement or coverage of such services. Vidacare is providing the information below to assist in this process, but disclaims any liability for the accuracy or appropriate use of such coding. In addition, the information below does not constitute legal or medical advice nor does Vidacare assume any liability for updating this information as new or different coding information becomes available.

BONE MARROW ASPIRATION AND BIOPSY; AND POWERED BONE MARROW BIOPSY MAY BE REPORTED USING THE FOLLOWING HCPCS CODES:

HCPCS CODES:	
CPT Code 38220	Bone Marrow, Aspiration only
CPT Code 38221	Bone Marrow, Biopsy, Needle or Trocar
G0364 (Medicare Use)	Bone Marrow Aspiration performed with Bone Marrow Biopsy through the same incision at the same date of service
C1830	Power Bone Marrow Biopsy Needle

Per Medicare guidelines, as outlined in the National Correct Coding Initiative Policy Manual, Chapter 5, Section E,¹ when bone marrow aspiration is performed alone, the appropriate code to report is CPT Code 38220. When a bone marrow biopsy is performed alone, the appropriate code to report is CPT Code 38221. CPT Code 38221 cannot be reported with CPT Code 20220 (bone biopsy).

CPT Codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or with two separate skin incisions over the same bone.

When a bone marrow biopsy (CPT Code 38221) and bone marrow aspiration (CPT Code 38220) are performed at the same site through the same skin incision, report only CPT Code 38221.

Use of CPT Code modifier “59” (distinct procedural service) – Medicare

Use of CPT Code modifier “59” appended to CPT Codes 38220 and 38221 should only be used if the two procedures are performed at separate sites or during separate patient encounters. If the procedures occur through the same incision, one should not use modifier “59” to report 38220 and 38221 together to Medicare. For sequenced procedures through the same incision, HCPCS Code G0364 should be used. In this case, report CPT Code 38221 for the biopsy as usual. The aspiration should then be reported using HCPCS Code G0364 (*Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service*).

Coding with commercial insurers

Providers should contact their payer for specific coverage guidelines before submitting claims for bone marrow aspiration and biopsy. Some commercial and managed care payers may have guidelines that allow one to report 38220 and 38221 for sequenced procedures. Others may require you to report only the most extensive procedure.

Coding for imaging services while performing a bone marrow biopsy and/or aspiration

According to the American College of Radiology,² image guidance for all of these procedures refers to the use of an imaging modality to identify the exact location of the area to be treated or sampled. The imaging is also used to ensure that the needle is placed in the correct location to obtain the biopsy. For most drainage, aspiration, and biopsy procedures, the work and cost of imaging is not included in the base code and should be reported separately. Imaging for needle placement is paid in addition to the biopsy/aspiration procedure.

BIOPSY AND ASPIRATION GUIDANCE CAN BE PERFORMED WITH FLUOROSCOPY, ULTRASOUND, OR CT USING THE FOLLOWING CPT CODES:

CPT Code 77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
CPT Code 76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
CPT Code 77012	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation

The choice of modality for imaging guidance depends on the site and characteristics of the fluid collection or lesion. Whatever modality is utilized, documentation of needle tip location in the physician notes is necessary.³

Payment Policies

Medicare payment policies are dictated by site of service with the likely sites of service for bone marrow aspiration and/or biopsy being the physician office (non-facility) setting and hospital outpatient (both hospital outpatient and ambulatory surgery center defined as facility setting).

Office setting: Physicians may have equipment on site with the capability for imaging guidance for use in performing a bone marrow aspiration/biopsy such as ultrasound, fluoroscopy, or CT. In this case the physician can bill for imaging while performing the bone marrow biopsy/aspiration and receive a global payment (consisting of the professional and technical components [TC]).

Hospital outpatient (ambulatory payment classification – APC): There is no separate technical payment available for imaging guidance procedures in these settings. Technical payments for imaging guidance are bundled into the APC overall payment. Physicians in these instances can bill separately for their services using the “26” modifier appended to the above imaging codes.

2011 Medicare Reimbursement Rates: The following are the 2011 national average reimbursement rates for bone marrow biopsy and/or aspiration.⁴ As well, national average reimbursement rates have been identified for the various imaging modalities that might be required in order to ensure correct needle placement.

2011-2012 Medicare Reimbursement Rates for C1830 (power bone marrow biopsy needle): The pass through payment for the OnControl™ device is the hospital’s charge for the device, adjusted to the actual cost for the device (based on the hospital specific cost-to-charge ratio), minus the amount included in the APC payment amount for the device.⁵ In the case of APC 0003 (bone marrow biopsy), the amount included in the APC 0003 payment is \$0.36.⁶



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2011 NATIONAL AVERAGE MEDICARE PAYMENTS FOR BONE MARROW BIOPSY/ASPIRATION AND IMAGING

		OFFICE SETTING (NON-FACILITY)			HOSPITAL OUTPATIENT OR FACILITY SETTING (APC 003)		
	DESCRIPTOR	Technical Component (TC)	Professional Component (26)	Global	Technical Component (TC)	Professional Component (26)	Global
CPT Code 38220	Bone Marrow, Aspiration Only	N/A	N/A	\$151.19	N/A	\$61.50	\$257.33
CPT Code 38221	Bone Marrow, Biopsy, Needle or Trocar	N/A	N/A	\$163.43	N/A	\$75.77	\$257.33
HCPCS Code G0364	Bone Marrow Aspiration performed with Bone Marrow Biopsy through the same incision at the same date of service (for Medicare only procedures. Billed in combination with CPT 38221 above)	N/A	\$13.36	\$ -	N/A	\$8.83	\$ -
CPT Code 77002	Fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device). When fluoroscopy is used for guidance with bone marrow aspiration and/or biopsy, not separately billable as an APC or ASC payment (e.g. fluoroscopy is bundled into APC 003 payment)	\$48.25	\$27.52	\$75.77	\$ -	\$27.52	\$ -
CPT Code 77012	Computed tomography guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), radiological supervision and interpretation. When CT used for guidance with bone marrow aspiration and/or biopsy, not separately billable as an APC or ASC payment (e.g. CT is bundled into APC 003 payment)	\$106.69	\$57.08	\$163.77	\$ -	\$57.08	\$ -
CPT Code 76942	Ultrasound guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), radiological supervision and interpretation. When ultrasound used for guidance with bone marrow aspiration and/or biopsy, not separately billable as an APC or ASC payment (e.g. Ultrasound is bundled into APC 003 payment)	\$164.45	\$33.64	\$198.09	\$ -	\$33.64	\$ -
HCPCS Code C1830	Power bone marrow biopsy needle	N/A	N/A	N/A	Reimbursement calculation: Charge X C/C ratio. Note: Reimbursement calculation applies to the hospital outpatient setting only. ASC reimbursement of C1830 is Medicare contractor priced. Therefore contact the individual Medicare carrier for specific pricing.		

Technical Component – Facility payment. Payment made for technical resources such as a technician’s time in operating a CT or MRI when a procedure is performed in a facility setting
“26” or Professional Component – Physician payment specifically for their time and effort in performing a procedure

- 1 NCCI Policy Manual for Medicare Services, Version 16.3, effective 10/1/10; accessed on 4/1/11 at: <http://www.cms.gov/NationalCorrectCodInitEd/>
- 2 Accessed on 4/1/11 at: http://www.acr.org/Hidden/Economics/FeaturedCategories/Pubs/coding_source/archives/NovemberDecember2005/ImageGuidedPercutaneousDrainageAspirationAndBiopsyProceduresDefinitionsProceduralDescriptionsA.aspx?css=print
- 3 American College Radiology Practice Guidelines
- 4 Medicare reimbursement rates as of April 1, 2011
- 5 Federal Register, 42 CFR Part 419, Friday, November 2, 2001, page 55857
- 6 2011 APC offset amount for supplies

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