Radioactive Seed Localization of Nonpalpable Breast Lesions

Policy Number: 6.01.57
Origination: 11/2016
Last Review: 11/2019
Next Review: 11/2020

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for Radioactive Seed Localization of Nonpalpable Breast Lesions when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered
Radioactive seed localization of nonpalpable breast lesions may be considered medically necessary for the purposes of locating lesions to guide excisional biopsy or breast-conserving surgery, because the clinical outcomes are likely to be equivalent to wire localization (see Considerations section).

When Policy Topic is not covered
n/a

Considerations
Based on the currently available evidence, radioactive seed localization of nonpalpable breast lesions is likely to produce equivalent outcomes compared with wire localization. Therefore, the “least costly alternative” provision of the medically necessary definition may apply.

When breast localization device(s) such as radioactive seeds are placed without biopsy, the procedure would be reported with codes 19281-19288, depending on the type of imaging guidance used and whether the lesion is an initial or subsequent lesion. If the breast localization device(s) is placed at the time of image-guided biopsy, it would be reported with codes 19081-19086, depending on the type of imaging guidance used and whether the lesion is an initial or subsequent lesion. The seeds might be reported with the tissue marker HCPCS code A4648.

State or federal mandates (eg, FEP) may dictate that certain U.S. Food and Drug Administration–approved devices, drugs, or biologics may not be considered investigational, and thus these devices may be assessed only on the basis of their medical necessity.
Radioactive seed localization of nonpalpable breast lesions is likely to produce equivalent outcomes compared with wire localization, but may be more costly. Some plans may use a definition of “medical necessity” that states that a medically necessary service must not be more costly than an alternative service or sequence of services that is at least as likely to produce equivalent health outcomes. In these cases, when it is determined that a strategy using radioactive seed localization is more costly than one using wire localization (as determined by plan pricing, provider charges, and/or other mechanisms), then radioactive seed localization may be considered not medically necessary for localization of nonpalpable breast lesions.

For contracts that do not use this definition of medical necessity, benefit or contract language describing the "least costly alternative" may also be applicable for this choice of treatment.

In addition, other contract provisions including contract language concerning use of out-of-network providers and services may be applied. That is, if the alternative therapy (eg, wire localization) is available in-network but radioactive seed localization is not, radioactive seed localization would not be considered an in-network benefit.

### Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Individuals:  
• With a nonpalpable breast lesion who are undergoing a procedure that requires lesion localization | Interventions of interest are:  
• Radioactive seed localization | Comparators of interest are:  
• Wire localization  
• Radio-guided occult lesion localization | Relevant outcomes include:  
• Other test performance measures  
• Resource utilization  
• Treatment-related morbidity |

Radioactive seed localization is used to detect nonpalpable breast lesions, which have become more common with increasing use of breast cancer screening in asymptomatic women. This technique is used before breast-conserving surgery or excisional biopsies, or to identify the location of an original cancer after neoadjuvant chemotherapy. A radiologist places a titanium “seed” containing radioactive iodine 125 with an 18-gauge needle using ultrasound, mammography, or stereotactic guidance. The surgeon then locates the seed and the breast tissue that needs to be removed, using a gamma probe. Alternative methods to localize nonpalpable breast lesions include wire localization (the traditional approach) or radio-guided occult lesion localization.

For individuals who have a nonpalpable breast lesion who are undergoing a procedure that requires lesion localization who receive radioactive seed localization, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are other test performance measures, resource utilization, and treatment-related morbidity. There are 3 RCTs comparing radioactive seed localization and wire localization, and overall they have found
similar outcomes (eg, rate of successful excision, rate of positive margins) with both techniques. Systematic reviews have also found that outcomes with both localization methods are similar. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

**Background**

**Nonpalpable Lesions**

More nonpalpable lesions are currently detected (about 25% to 35% of breast cancers at diagnosis) due to the increased use of breast screening in asymptomatic women. These nonpalpable lesions require a localization technique to perform excisional biopsies or breast-conserving surgery (ie, lumpectomy).

**Localization Methods**

The traditional localization method for nonpalpable breast lesions is image-guided wire localization. This approach has limitations, including the following: the wire can bend or be displaced (because the wire protrudes from the breast); there may be scheduling issues given the wire should be placed on the same day as the surgery; and the radiologist may follow a different route to place the wire than the surgeon does to excise the lesion, which may complicate locating all of the lesion (in addition to potentially causing cosmetic concerns). The percentage of cases with positive margins after wire localization is 14% to 47%.

Radioactive seed localization of nonpalpable breast lesions uses radio-opaque titanium seed(s) containing radioactive iodine 125 (I-125). These seeds are inserted by a radiologist using ultrasound or stereotactic guidance to identify the location of a nonpalpable breast lesion. They may be placed several days or weeks before surgery. The surgeon then uses a gamma probe to locate the radioactive seed and remove it with surrounding tissue. One study mentioned that the radiation dose associated with I-125 seeds (0.29 mCi) was less than that for a mammogram or chest radiograph. The range of radioactive doses in 1 group of studies was 3.7 to 10.7 MBq (1 MBq=0.027 mCi). Seeds were 4.5x0.8 mm, which has been described as similar in size to a grain of rice. The half-life of I-125 is 60 days, and I-125 is a 27-keV source of gamma radiation. I-125 can be detected on a different signal than the 140-keV technetium 99 (Tc-99) that may be used for sentinel lymph node biopsy. Once the radioactive seed is removed, its presence in the tumor specimen is confirmed using the gamma probe. Lack of radioactivity in the tumor cavity is also assessed to ensure that the radioactive seed has not been left in the breast. A disadvantage of radioactive seed localization is that special procedures must be followed to safely handle and track the radioactive seed before placement and after excision.

Radioactive seed localization also may be used to guide excision after neoadjuvant chemotherapy, which is performed primarily in women with locally advanced cancer in an effort to shrink the tumor. A proportion of these women (25%-32%) are then able to have breast-conserving surgery rather than a mastectomy. The challenge is that if there is a complete clinical and radiologic response, it may be difficult to localize the original tumor bed. Pathologic confirmation of response
is needed because there is residual microscopic cancer in about half of these patients. Radioactive seed localization can mark the tumor location before beginning neoadjuvant chemotherapy.

An alternative to wire localization or radioactive seed localization, developed in the late 1990s, is radio-guided occult lesion localization. First, a twist marker is placed in the breast to identify the tumor. Before surgery, a liquid radioactive radiotracer (Tc-99) is injected next to the twist marker using image guidance. The surgeon uses a gamma probe to locate the radiotracer and guide the incision. The main disadvantage of this approach is that the radiotracer has a short half-life (»6 hours). It also does not provide a point source of radiation. An advantage is that Tc-99 may be used for sentinel lymph node biopsy, so the same radiotracer is used for both purposes. Alternatively, a radioactive seed and Tc-99 for sentinel lymph node biopsy can be used concurrently. Another alternative is intraoperative ultrasound-guided resection, although the procedure is discussed less frequently in this literature. It can only be done when the lesion is detectable by ultrasound.

**Regulatory Status**

In 2011, the BrachySciences Radioactive Seed Localization Needle with AnchorSeed™ (Biocompatibles) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process (K111979). This device is indicated for the localization of suspicious tissues (nonpalpable lesions) for excision with the use of radioactive seeds.

In 2012, the Best® Localization Needle with I-125 Seed (Best Medical International) was cleared for marketing by FDA through the 510(k) process (K122704). This device is indicated for breast localization under the direct supervision of a qualified physician. It comprises an I-125 seed and an 18-gauge 5- to 20-cm needle.

These devices are not always used for radioactive seed localization. Radioactive seeds approved for another indication (ie, off-label) may also be implanted with an 18-gauge needle. These seeds were initially approved for permanent implantation (ie, brachytherapy) in select localized tumors such as prostate cancer. These seeds use I-125 beads (activity from 0.1 to 1.0 mCi) encapsulated in a titanium tube. An example is the International Isotopes I3RAD I-125 Seed, which, in 1999, was cleared for marketing by FDA through the 510(k) process (K992963). FDA product code: KXK.

**Rationale**

This evidence review was created in September 2013 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through July 9, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function¾including benefits and
harm. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Radioactive Seed Localization**

**Clinical Context and Therapy Purpose**

The purpose of implanting localized radioactive seeds in patients who have a nonpalpable breast lesion and are undergoing a procedure that requires lesion localization is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does implantation of localized radioactive seeds improve the net health outcomes of individuals with a nonpalpable breast lesion that requires lesion localization prior to surgical excision?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest is individuals with a nonpalpable breast lesion that requires lesion localization prior to surgery.

**Interventions**

The therapy being considered is implantation localized of radioactive seeds.

**Comparators**

The following therapies are currently being used to make decisions about identifying nonpalpable breast lesions: wire localization and radio-guided occult lesion localization.
Outcomes
The general outcomes of interest are the accuracy of breast lesion localization, surgical margins, and reoperation rates.

Timing
Short-term follow-up is necessary to ensure positive surgical margins.

Setting
Implantation of radioactive seeds is performed in a radiology outpatient setting.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess longer term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Systematic Reviews
Several systematic reviews have compared radioactive seed localization (RSL) with other localization methods. A Cochrane review by Chan et al (2015) evaluated RCTs comparing localization techniques to guide surgical excision of nonpalpable breast lesions. Fourteen RCTs were identified; 2 compared RSL with wire localization (WL), 6 compared radio-guided occult lesion localization with WL, and 3 used less common techniques. The primary outcomes were the successful localization of the lesion, successful excision of the lesion, positive excision margins, and the need for further excision. Meta-analyses were conducted for several of these outcomes for RSL and WL. There were no significant differences in the rates of successful excision with RSL or WL (relative risk, 1.00; 95% CI [confidence interval], 0.99 to 1.01) or rates of positive margins (relative risk, 0.67; 95% CI, 0.43 to 1.06). Reviewers concluded that the published evidence did not clearly support one localization method over another.

A meta-analysis by Pouw et al (2015) included studies evaluating RSL, with or without a comparator intervention. Sixteen studies were identified; the number of patients in individual studies ranged from 13 to 2222. Among the included studies, 6 compared RSL with WL, one compared RSL with radio-guided occult lesion localization, and the remaining studies were uncontrolled. However, this systematic review only reported outcomes for the RSL cases. The primary outcomes were irradicality (ie, positive margins) and for re-excision. In the 16 studies, the average proportion of patients with irradicality was 10.3% (range, 3.0%-30.3%) and the average re-excision rate was 14.2% (range, 4.0%-42.0%).

Ahmed et al (2013) published a systematic review and meta-analysis of RCTs and nonrandomized controlled studies of RSL and WL. Positive margins for wide local
incision were significantly less likely for RSL vs WL (odds ratio, 0.51; 95% CI, 0.36 to 0.72; \( p < 0.001 \)) for 5 studies. Reoperations were less likely for RSL (odds ratio, 0.47; 95% CI, 0.33 to 0.69; \( p < 0.001 \)) for the 4 trials included. Shorter surgery was significantly more likely using RSL than WL (mean difference, -1.32 minutes; 95% CI, -2.32 to -0.32 minutes; \( p = 0.01 \)) for the 2 trials included. Based on 2 trials, there was no statistically significant difference in the volume of breast tissue excised during surgery (mean difference, 1.46 cm\(^3\); 95% CI, -22.35 to 25.26 cm\(^3\); \( p = 0.90 \)).

**Randomized Controlled Trials**

Three RCTs (2 included in the Cochrane reviews, 1 newer RCT) are described below and summarized in Tables 1 (characteristics) and 2 (results).

Bloomquist et al (2016) published an RCT comparing RSL (\( n = 70 \)) with WL (\( n = 55 \)).\(^7\) The trial included adult women with nonpalpable invasive carcinoma or ductal carcinoma in situ who were eligible for breast-conserving surgery (BCS). Multifocal disease and extensive disease requiring bracketing were not exclusion criteria. The primary outcomes were patient-reported assessment of procedure-related pain and overall convenience of the procedure. Patients in the RSL group completed a questionnaire immediately after the procedure and patients in the WL group completed a questionnaire at the first postoperative visit. The difference in timing could have biased outcomes (eg, patients may remember pain during the procedure differently by the time they had a postoperative visit). Pain was measured on a 1- (no pain) to 5- (severe pain) point Likert-type scale. Convenience was also rated from 1 (poor convenience) to 5 (excellent convenience). Median pain scores during the procedure did not differ significantly between groups. However, the convenience of RSL was rated significantly higher than WL. The median convenience score was 5 in the RSL group and 3 in the WL group (\( p < 0.001 \)).

Surgical outcomes were also reported. There was no significant difference in the rate of positive margins (RSL=19.4% vs WL=15.3%; \( p = 0.053 \)). There were also no significant differences in the volume of extracted tissue: the mean volume was 77.0 cm\(^2\) in the RSL group and 67.4 cm\(^2\) in the WL group (\( p = 0.67 \)). All targeted lesions were successfully excised, and there were no lost seeds or transected wires.

Lovrics et al (2011) published the findings of an RCT assessing 205 patients.\(^8\) Participants had nonpalpable early-stage breast cancer and were undergoing BCS. Randomization to RSL or WL was centralized, concealed, and stratified (by surgeon for 7 surgeons). The 2 groups were similar except that multifocal disease was more common in the RSL patients. Mean age was about 60.9 years for both arms. Exclusion criteria included male patients, pregnancy or lactation, multicentric or locally advanced disease, lobular carcinoma in situ only, and contraindications for BCS. Localization was performed using mammography or ultrasound on the day of surgery. Tumor location was confirmed using 2-view mammography. An intention-to-treat analysis was performed, and the power calculation was reported: A sample size of 333 patients could detect a 15%
difference in positive margins across arms with 80% power at a 5% significance level.

In the RSL arm, 18 patients had WL > 6 because the seed was not available at surgery; 3 because the seed would not deploy; and 2 because the seed was displaced. For 7 patients, no explanation was provided. In 3 cases, the wire was added to seed localization to bracket larger lesions. One seed and 2 wires migrated, and 1 wire fell out during surgery.

All index lesions were removed. There were no between-group differences, except the following: the mean surgical time was shorter for RSL (19.4 minutes vs 22.2 minutes, respectively; p<0.001); surgeons found excision after RSL easier (p=0.008); and patients found RSL less painful (p=0.038). However, there was no statistically significant difference in patients’ anxiety level. There were no between-group differences in the proportion of positive margins (10.5% for RSL vs 11.8% for WL) or reoperation rates. Results for positive margins were similar when the analysis was rerun based on the treatment patients received (per protocol analysis). Also, the percentage of positive margins was higher for ductal carcinoma in situ (20.4%) than for invasive cancer (9.2%; p=0.020). A related study by Reedijk et al (2012) analyzed factors associated with positive margins, including localization under stereotactic guidance, in situ disease, large tumor size, and multifocal disease.9,

Gray et al (2001) randomized 97 women with nonpalpable breast lesions to RSL (n=51) or WL (n=47).1, The method of randomization was not reported. Fifty-six patients underwent excisional biopsies for suspicious lesions judged inappropriate for percutaneous biopsy techniques, and 41 patients with a confirmed diagnosis of breast cancer by core needle biopsy had BCS (47% of RSL patients, 37% of WL patients). Both WL and RSL were performed using ultrasound or mammography guidance. Surgery was performed up to 5 days later.

Fifty-two patients had invasive carcinoma; 9 had ductal carcinoma in situ, and 36 had benign lesions. There were no statistically significant differences in the number of patients with RSL or WL within each category. Outcomes for both localization techniques were similar for migration of the localization device (ie, seed or wire); ability to locate the lesion during surgery; time for radiographic localization and for surgical excision; subjective ease of the procedure for radiologists, patients, or surgeons; and volume of tissue removed. Specimen radiographs were used with WL but not with RSL. There were fewer positive margins with RSL (26%) than with WL (57%; p=0.02).
### Table 1. Summary of Key Randomized Controlled Trial Characteristics for RSL and WL

<table>
<thead>
<tr>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomquist et al</td>
<td>U.S.</td>
<td>1</td>
<td>2011-2014</td>
<td>125 women with nonpalpable breast lesions</td>
<td>RSL=70, WL=55</td>
</tr>
<tr>
<td>(2016)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lovrics et al</td>
<td>Canada</td>
<td>3</td>
<td>2004-2010</td>
<td>305 women with invasive or ductal carcinoma in situ</td>
<td>RSL=152, WL=153</td>
</tr>
<tr>
<td>(2011)</td>
<td></td>
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<td></td>
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<tr>
<td>Gray et al</td>
<td>U.S.</td>
<td>1</td>
<td>1999-2001</td>
<td>97 women with nonpalpable breast lesions</td>
<td>RSL=51, WL=47</td>
</tr>
<tr>
<td>(2001)</td>
<td></td>
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</table>

RSL radioactive seed localization; WL: wire localization.

### Table 2. Summary of Randomized Controlled Trial Results for RSL and WL

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Localization device migration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSL</td>
<td>6 seeds</td>
<td>1 seed</td>
<td>No substantial migration</td>
</tr>
<tr>
<td>WL</td>
<td>7 wires</td>
<td>2 wires; 1 wire fell out</td>
<td>No substantial migration</td>
</tr>
<tr>
<td>Removal of suspicious lesion</td>
<td>100% for both</td>
<td>100% for both</td>
<td>100% for both</td>
</tr>
<tr>
<td>Positive margin rate, n (%)</td>
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<td></td>
<td></td>
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<tr>
<td>RSL</td>
<td>14 (19.4)</td>
<td>16 (10.5)</td>
<td>26%</td>
</tr>
<tr>
<td>WL</td>
<td>9 (15.3)</td>
<td>18 (11.8)</td>
<td>57%</td>
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<td>-------------------------</td>
<td>-------------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>p</td>
<td>0.53</td>
<td>0.990</td>
<td>0.02</td>
</tr>
<tr>
<td>Re-excision rate, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSL</td>
<td>NR</td>
<td>17 (11.2)</td>
<td>NR</td>
</tr>
<tr>
<td>WL</td>
<td>NR</td>
<td>20 (13.1)</td>
<td>NR</td>
</tr>
<tr>
<td>p</td>
<td></td>
<td>0.786</td>
<td>NR</td>
</tr>
<tr>
<td>Patient rating</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>· Pain (NS)</td>
<td></td>
<td>· Pain with RSL less than with WL (p=0.038)</td>
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<tr>
<td>· Convenience:</td>
<td></td>
<td>· Anxiety (NS)</td>
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<tr>
<td>Significantly higher</td>
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<td></td>
<td></td>
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<tr>
<td>for RSL than WL</td>
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<td></td>
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<tr>
<td>(p&lt;0.001)</td>
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</table>

NR: not reported; RSL: radioactive seed localization; WL: wire localization.

**Summary of Evidence**
For individuals who have a nonpalpable breast lesion who are undergoing a procedure that requires lesion localization who receive radioactive seed localization, the evidence includes RCTs and systematic reviews. Relevant outcomes are other test performance measures, resource utilization, and treatment-related morbidity. Three RCTs have compared radioactive seed localization with wire localization, and overall, they have reported similar outcomes (eg, rates of successful excision, the rate of positive margins) with both techniques. Systematic reviews have also found that outcomes with both localization methods are similar. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**SUPPLEMENTAL INFORMATION**

**Practice Guidelines and Position Statements**
The American College of Radiology (2013; amended 2014) issued practice guidelines for imaging management of ductal carcinoma in situ and invasive breast carcinoma. Both wire localization (using mammographic, sonographic, or magnetic resonance imaging guidance) and radioactive seed localization (using mammographic or sonographic guidance) as techniques for preoperative image-guided localization of nonpalpable breast lesions are discussed as techniques to guide surgeons.
U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 3.

Table 3. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02800317</td>
<td>Primary Radioactive Iodine Seed Localisation in the Axilla in Axillary Node Positive Breast Cancer Combined With Sentinel Node Procedure (RISAS) Following Neoadjuvant Chemotherapy</td>
<td>200</td>
<td>Oct 2018</td>
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<tr>
<td>NCT02522468</td>
<td>A Trial of RSL Versus WL for Malignant Breast Disease (BCS-RSL-001)</td>
<td>400</td>
<td>Jul 2020</td>
</tr>
<tr>
<td>Unpublished</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>NCT01901991</td>
<td>Localization of Nonpalpable Breast Lesions</td>
<td>410</td>
<td>Feb 2016 (completed)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

REFERENCES
Radioactive Seed Localization of Nonpalpable Breast Lesions 6.01.57


Billing Coding/Physician Documentation Information

**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

**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)

**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

**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)

**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

**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)

**19281** Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

**19282** Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code
for primary procedure)

19283 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance

19284 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

19285 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance

19286 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

19287 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance

19288 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

A4648 Tissue marker, implantable, any type, each

ICD-10 Codes

C50.011-C50.929 Malignant neoplasm of breast, code range

D05.00-D05.92 Carcinoma in situ, breast, code range

D48.60-D48.62 Neoplasm of uncertain behavior of breast, code range

Additional Policy Key Words

N/A

Policy Implementation/Update Information

11/1/16 New Policy, considered Medically Necessary.
11/1/17 No policy statement changes.
11/1/18 No policy statement changes.
11/1/19 No policy statement changes.