Part B Insider (Multispecialty) Coding Alert

Biopsy Coding: Adopt This 3 Step Approach for Accurate Bone Biopsy Claims

You can report biopsy with excision, destruction, removal, repair or fixation procedures.

Want to make your bone biopsy coding error-free? Make sure you understand 'incisional' and 'excisional' biopsies. Don't only rely on these two terms to guide your coding. The results of the biopsy should also weigh in and guide the decision for proper code selection. You can make your way to successful coding by following these three (3) steps.

Step 1: Same Code Describes Excisional, Incisional Biopsies

Because CPT® doesn't always specify exactly what the surgeon performed, you may not be able to nail down the appropriate bone biopsy code without looking further into the surgeon's notes.

Consider the following scenario: The surgeon identifies a bone lesion on the tibia and takes the patient to the OR. The physician makes an incision, takes a sample from the lesion and sends the sample to pathology. After pathology confirms the lesion is not malignant, the surgeon curettes the lesion.

Coding challenges: Which code should you report for the biopsy? And can you report the benign tumor curettage as well?

Although some insurers still refer to the 20240 (Biopsy, bone, open; superficial [e.g., ilium, sternum, spinous process, ribs, trochanter of femur]) series as excisional biopsy codes, CPT® clearly identifies 20240 as an "open" procedure. You can, however, report 20240 and 20245 (... deep [e.g., humerus, ischium, femur]) for both incisional and excisional biopsies.

Step 2: Biopsy Results Dictate Excision Coding

Once you identify 20240 as the appropriate code choice for the biopsy, you'll need to determine whether you can also report the curettage.

Good news: According to National Correct Coding Initiative (CCI) guidelines, because the physician couldn't proceed with the excision until he knew the results of the biopsy, you can report both codes.

The NCCI dictates, "In the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, removal, repair or fixation procedure) is dependent on the results of the biopsy procedure, the biopsy procedure may be separately reported." National Correct Coding Initiative Policy Manual, Chapter 4; pg. 6: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Therefore, you should report 20240 along with 27635 (Excision or curettage of bone cyst or benign tumor, tibia or fibula) to describe both procedures. If the patient is a Medicare beneficiary, you should append modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period) to 27635. The NCCI guidelines also state, "If, at the same session, a biopsy is necessary to establish the need for surgery, modifier 58 would be used to indicate this."

Step 3: Add More Units of 20245 When Necessary

Suppose your physician performs several bone biopsies during the same session. For example, he takes a bone biopsy of the distal tibia and a separate bone biopsy of the talus.

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Coding solution: You should report two units of 20245. Although the physician biopsied two lesions, he gained surgical access to them through separate incisions, so you can code and bill for both procedures.

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