Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Gynecology: Answer 3 Questions to Bolster Your Biopsy Coding Efficiency

The number of biopsy units doesn't always go by the number of samples.

Are you sure you're getting the reimbursement your ob-gyn deserves for biopsy procedures? Take this quiz and avoid the many pitfalls of biopsy coding and billing.

Background: A biopsy is a tissue sample that the ob-gyn excises from the patient to ascertain the presence of cancer. Ob-gyns will most likely perform biopsies of the vulva, cervix, vagina, endometrium and ovary(s). Ob-gyns usually order a biopsy as a result of abnormal vaginal bleeding or after the detection of a mass, cyst, lump, tumor or cells of abnormal appearance.

Best bet: You should code all of your biopsies with the copy of the pathology report to back up your diagnoses. Make this a rule when you're coding biopsies, and your claim is sure to sail.

Scenario 1: Lap-to-Open Biopsy Procedure Requires This Code

The ob-gyn performs an ovarian biopsy laparoscopically. The biopsy reveals malignancy, so the ob-gyn converts to an open procedure to remove the ovary(s). What should you report?

Solution: The code for a laparoscopic ovarian biopsy is 49321 (Laparoscopy, surgical; with biopsy [single or multiple]). If the intraoperative biopsy reveals malignancy, the ob-gyn may convert to an open procedure to remove the ovary(ies) (for example, 58940, Oophorectomy, partial or total, unilateral or bilateral).

Note: You cannot report 58950 (Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy) even though the results came back as a malignancy, because the ob-gyn did not perform an omentectomy.

At this point, most payers will consider the biopsy part of the more extensive procedure, but some may reimburse 49321 separately, especially if future surgery was contingent on the biopsy result (i.e., the patient was not originally scheduled for a BSO). If the work involved in performing the laparoscopy and obtaining the biopsy was significant and well documented, you may use modifier 22 (Unusual procedural services) appended onto 58940 (Oophorectomy, partial or total, unilateral or bilateral) to obtain higher reimbursement. Your payer will decide if they want it billed separately or if they want the extensive procedure with modifier 22 option.

Don't forget: If the ovarian biopsy revealed malignancy, you'll likely attach a diagnosis like malignant ovarian neoplasm (183.0) for 58940. Be careful though. You should never code malignant because the ob-gyn states it looks malignant without pathology confirming it.

Scenario 2: Look For These Additional Coding Opportunities

A patient with irregular intermenstrual bleeding (626.6) undergoes an office procedure in which the ob-gyn extracts samples from the tissue lining the inside of the uterus (endometrium). He inserts a plastic catheter into the uterus and suctions out a small amount of the endometrial lining. What should you report?

Solution: This is an endometrial biopsy, so you should report 58100 (Endometrial sampling [biopsy] with or without endocervical sampling [biopsy], without cervical dilation, any method [separate procedure]). This code is a fairly straightforward procedure that an ob-gyn does in the office, without general or local anesthesia in most cases.

Keep in mind: You can report 58100 with a preventive or problem-oriented E/M visit by attaching modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to the E/M code if the ob-gyn documented a separate significant E/M service. If the patient reports for a biopsy and the ob-gyn planned or conducted no other service, however, you should report the biopsy code on its own.

Also, if your ob-gyn performs an endometrial biopsy in addition to a colposcopy, you should use the add-on code +58110 (Endometrial sampling [biopsy] performed in conjunction with colposcopy [list separately in addition to code for primary procedure]) instead of 58100.

Scenario 3: Count Your Lesions Carefully

A patient presents with an abnormal mole, lesion or other dermatosa on the vulva that hasn't responded to topical or other conventional treatments. With topical anesthesia, the ob-gyn takes three samples. What should you report?

Solution: The CPT codes for vulva biopsy are 56605 (Biopsy of vulva or perineum [separate procedure]; one lesion) and +56606 (... each separate additional lesion [list separately in addition to code for primary procedure]).

Code 56606 is an add-on code, and its definition indicates that you can report it in multiples -- in other words, for every lesion the ob-gyn excises after the first one. If the ob-gyn biopsies three separate lesions, the claim form would read, line by line:

- 56605
- 56606 x 2.

You should note that there is no modifier listed with 56606 because this code is an add-on one.

Heads up: You should not report all biopsies this way. In the case of a colposcopy and biopsy(s) of the cervix (57455, Colposcopy of the cervix including upper/adjacent vagina; with biopsy[s] of the cervix), you should only submit one code -- even if the ob-gyn takes three samples in the same area. The lab will bill for the three specimens it received.