Part B Insider (Multispecialty) Coding Alert

Reader Question: Modifier PT Doesn't Apply to Pathology

Question: We billed 88305 and 88342 with modifier PT for a diagnosis of V76.51 and 211.3. The payer denied the 88342 charge. How should we bill this, and should we use a modifier? Also, what date of service should we use if the pathology service was not on the same date as the biopsy?

Answer: Assessing what coding issues might have led to the denial is difficult, because you don't state what specimen your pathologist diagnoses, or what stain the pathologist uses.

Based on the diagnosis codes (V76.51, Special screening for malignant neoplasms colon, and 211.3 Benign neoplasm of colon), let's assume the pathologist is interpreting a colon biopsy. The correct code for a colon biopsy exam would be 88305 (Level IV - Surgical pathology, gross and microscopic examination, Colon, biopsy).

Then, assuming that the pathologist documents a qualitative immunohistochemistry (IHC) stain, you would be correct to report 88342 (Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide) (revised CPT® 2014 definition). You should have no problem reporting 88305 and 88342 together, and doing so should not require any modifier.

Modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure), which you mention, is for the surgeon to use when converting a screening colonoscopy to a diagnostic colonoscopy. The modifier doesn't apply to pathology.

The pathologist would normally report the diagnosis code based on the findings of the biopsy and IHC stain exams. For colonoscopies, some payers want the screening diagnosis as well. Only your payer can tell you for certain why you're getting a denial for the 88342 charge.

Date of service: Regarding your final question about date of service, you should use the date the biopsy was taken if you're reporting the technical component of 88305. That's true if you're billing globally or billing only the technical work. There's no guidance that requires you to report the professional component (pathologist interpretation) on the date the specimen is taken, but many pathology practices choose to use that date for consistency across technical, global, and professional component claims.