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Part B Insider (Multispecialty) Coding Alert

Reader Question: Payers May Disagree About Colon Biopsy Diagnosis Code

Question: When our pathologist examines a colon biopsy from a screening colonoscopy (turned diagnostic), should we report the screening ICD-9 code or the pathology report findings as the diagnosis?

Answer: The answer to your question may depend on the payer. Generally, you should report the diagnosis to the highest degree of certainty known at the time of billing, which would mean using the pathology report findings such as 211.3 (Benign neoplasm of other parts of digestive system; colon).

Payers may differ: Depending on your Medicare contractor or other payer rules, you may need to list first the screening code (V76.51, Special screening for malignant neoplasms; colon) to show that the procedure started as a screening colonoscopy.

Here's why: Although the pathologist uses the same charge code for a colon biopsy (88305, Level IV - Surgical pathology, gross and microscopic examination, colon, biopsy) without regard to whether the physician ordered a screening colonoscopy, the surgeon uses different codes, and the distinction has coverage implications (100 percent for screening versus less for diagnostic).

That distinction has caused Medicare to require surgeons to list first the screening ICD-9 code, regardless of pathologic findings, and to list the procedure code with modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure).

Some payers have carried the ICD-9 coding requirement forward to the pathology report, and you should comply with the instruction, which could impact coverage for the patient.

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