Codify by AAPC

Outpatient Facility Coding Alert

Reader Question: Hold Your Codes Until Path Report Is In

Question: Is there a hard-and-fast billing rule that requires us to wait for the pathology report to send out our surgeon's claims?

Vermont Subscriber

Answer: While there is no hard-and-fast rule that requires you to wait for the pathology report before billing the surgeon's work, doing so is to your advantage. Read on to see three good reasons why you should wait for the path report:

1. Because ICD-9 outpatient coding guidelines state that you should not code a "rule-out" diagnosis, you'll be left coding signs and symptoms if you don't wait for the path report. For instance, if your surgeon performs a breast biopsy, you'll need to report something like 611.72 (Lump or mass in the breast) instead of a specific code such as 174.x (Malignant neoplasm of female breast).

2. The final diagnosis might impact your procedure code. For instance, you'll choose different procedure codes for benign versus malignant lesion removal (such as 11446, Excision, other benign lesion including margins, except skin tag [unless listed elsewhere], face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm, or 11646, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm.).

3. You might lose opportunities to report additional procedures based on pathology. For instance, you can separately report an appendectomy during another abdominal procedure using +44955 (Appendectomy; when done for indicated purpose at time of other major procedure [not as separate procedure] [List separately in addition to code for primary procedure]) if you have documentation (such as a pathology report) indicating a distinct medical need for the surgeon to remove the appendix.

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