Billing and Reimbursement Guideline: Biopsy Services, Laboratory and Pathology

Guideline Publication Date: September 1, 2010

Key coding, documentation and reimbursement points include:

- If a biopsy is performed during a surgical excisional procedure and the removed tissue is sent for pathology or culture, the excised tissue is considered a routine part of the excisional procedure and as such is not billable. Biopsies cannot be billed if they are part of the lesion removal.
- Multiple biopsies from the same lesion are coded as a single biopsy.
- If the surgical note indicates that the entire lesion was removed, then the procedure is not coded as a biopsy but as an excision.
- The medical record should document the distinct anatomical location and description of the biopsy (ies), how the tissue was obtained, and a copy of the pathology or culture report to validate medical necessity.
- Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. If an excision was performed from one site and a biopsy taken from another lesion, then a modifier 59 is added to the biopsy code along with any relevant anatomical modifiers.
- This guideline applies to CMS-1500 claim submissions.
- This guideline applies to place of service 11 and 22.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

Version History	
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